Maternal and Child Health Services Title V Block Grant

State Narrative for New Jersey MCH Block Grant

Application for 2017
Due July 2016

Table of Contents

I. General Requirements

The New Jersey Title V MCH Block Grant Application/Annual Report was developed according to the seventh edition of the Title V MCH Block Grant to States Application/Annual Report Guidance which consists of two documents: 1) Guidance And Forms For The Title V Application/Annual Report; and 2) Appendix of Supporting Documents, which includes background program information and other technical resources.

As with previous editions, this Guidance adheres to the specific statutory requirements outlined in Sections 501 and 503-509 of the Title V legislation and promotes the use of evidence-based public health practices by states/jurisdictions in developing a Five-Year Action Plan that addresses identified MCH priority needs. The revised Guidance also reaffirms the mission of Title V as “to improve the health and well-being of all of America’s mothers, children, and families.”

1. D. Table of Contents

This report follows the outline of the Table of Contents provided in the "Guidance And Forms For The Title V Application/Annual Report," Omb No: 0915-0172; expires January 31, 2017.

1.E. Application/Annual Report Executive Summary *(limit 15,000 characters, 5 pages)*

The mission of the Division of Family Health Services (FHS) is to improve the health, safety, and well-being of families and communities in New Jersey. The Division works to promote and protect the health of mothers, children, adolescents, and at-risk populations, and to reduce disparities in health outcomes by ensuring access to quality comprehensive care. Our ultimate goals are to enhance the quality of life for each person, family, and community, and to make an investment in the health of future generations. The Maternal and Child Health Block Grant Application and Annual Report that FHS submits each year to the Maternal Child Health Bureau (MCHB) provides an overview of initiatives, State-supported programs, and other State-based responses designed to address the maternal and child health (MCH) needs in New Jersey (NJ) as identified through our continuous needs assessment process and in concert with the Department of Health (NJDOH) strategic plan, the States’ Health Improvement Plan, Healthy NJ 2020, and the collaborative process with other MCH partners.

NJ is the most urbanized and densely populated state in the nation with 8.9 million residents. It is also one of the most racially and ethnically diverse states in the country. The racial and ethnic mix for NJ mothers, infants, and children is more diverse than the overall population composition. This growing diversity not only raises the importance of addressing disparities in health outcomes and improving services to individuals with diverse backgrounds but also of the need to ensure a culturally competent workforce and service delivery system. Indeed, one of the three priority goals of the FHS Title V program is to increase the delivery of culturally competent services. The other two goals are to improve access to health services through partnerships and collaboration and to reduce disparities in health outcomes across the lifespan consistent with the Life Course Perspective (LCP).

Currently, FHS/Title V is collaborating with the NJDOH Office of Multicultural and Minority Health in completing a modified version of the cultural and linguistic competency assessment developed at the request of the Bureau of Primary Health Care by the National Center for Cultural Competence. The goal is to identify strengths, areas for growth and improvement that will lead to policy development, strategic planning and further quality improvement processes. FHS expects to enhance our service quality within culturally diverse communities leading to positive outcomes.

The goals and State Priority Needs (SPNs) selected by FHS are consistent with the findings of the Five-Year Needs Assessment, built upon the work of prior MCH Block Grant Applications/Annual Reports and in alignment with NJDOH's and FHS' goals and objectives. These are (1) Increasing Healthy Births, (2) Improving Nutrition and Physical Activity, (3) Reducing Black Infant Mortality, (4) Promoting Youth

Development, (5) Improving Access to Quality Care for CYSHCN, (6) Reducing Teen Pregnancy, (7) Improving & Integrating Information Systems, and (8) Smoking Prevention. Title V services within FHS will continue to support enabling services, population-based preventive services, and infrastructure building to meet the health of all NJ's families.

Based on NJ's eight selected SPNs as identified in the Five-Year Needs Assessment, NJ has selected the following ten of 15 possible National Performance Measures (NPMs) for programmatic emphasis over the next five-year reporting period:
NPM #1 Well woman care,
NPM #4 Breastfeeding,
NPM #5 Safe Sleep,
NPM #6 Developmental Screening,
NPM #8 Physical activity,
NPM #10 Adolescent Preventive Medical Visit
NPM #11 Medical Home,
NPM #12 Transitioning to Adulthood,
NPM #13 Oral Health, and
NPM #14 Household Smoking.

During a period of economic hardship and federal funding uncertainty, challenges persist in promoting access to services, reducing racial and ethnic disparities, and improving cultural competency of health care providers and culturally appropriate services. Thus evaluating existing programs to ascertain effectiveness is also a top priority for the FHS. As a result of our continuing quality improvement and evaluation process, the Access to Prenatal Care (Access) Initiative (2010-2013) was replaced, in 2014, by evidence based models and the initiative re-named Improving Pregnancy Outcomes (IPO) when the results of the Access Initiative did not produce the expected outcomes.

The IPO Initiative grants were awarded in 2014 through a request for proposals process. The IPO Initiative which promotes a LCP targets public health resources to communities with the highest need utilizing two models, Community Health Workers (CHWs) and Central Intake (CI) to improve quality access across three key life course stages: preconception, prenatal/postpartum and interconception care as a means to decrease infant mortality rates. The CHW model performs outreach and client recruitment within the targeted community to identify and enroll women and their families in appropriate care. The second model, Central Intake, is a single point of entry for screening and referral of women of reproductive age and their families to necessary medical and social services. Central Intake works closely with community providers and partners, including CHWs, to eliminate duplication of effort and services. Standardized screening tools are used and referrals to programs and services are tracked in a centralized web-based system (single point of entry and client tracking).

Augmenting the IPO Initiative is our participation in 2014 in the National Governors Association (NGA) Center for Best Practices' Learning Network on Improving Birth Outcomes (NGA IBO) Initiative. This initiative enabled NJ to explore evidence-based strategies shown to be effective in addressing poor birth outcomes. The first in-state meeting held on January 13, 2014 explored critical issues and set the agenda for future activities. This meeting, attended by a wide array of public and private partners, provided an awareness of NJ's prematurity rates and other related maternal and child health indicators and discussed the steps necessary to further move the needle on these important health indicators. Three major workgroups (Payors, Data, and Wellness) were formed to explore the issues in-depth and develop recommendations for further action. A meeting was held June 2015 with the Commissioner of Health where final recommendations with action steps and specified responsible entities for accomplishing outcomes were present.

In 2014 FHS also participated in the Collaborative Improvement & Innovation Network to Reduce Infant Mortality (IM CoIIN) sponsored by the MCH Bureau. The IM CoIIN State Team from NJ identified two priority areas - improving maternal postpartum visit rates and smoking cessation for pregnant and post-partum women. The NGA IBO Initiative workgroups will continue as the IM CoIIN Strategy Teams work towards improving birth outcomes and preventing infant mortality.

Another program promoting the LCP and augmenting our efforts to reduce infant mortality, pre-term births and maternal morbidity and mortality is the Maternal and Infant Early Child Home Visiting (MIECHV) Program which has expanded Home Visiting (HV) across all 21 NJ counties with 5,339 families participating in HV during SFY 2014. The goal of the NJ MIECHV Program is to expand NJ's existing system of home visiting services which provides evidence-based family support services to: improve family functioning; prevent child abuse and neglect; and promote child health, safety, development and school readiness.

Three other initiatives that are contributing towards positive outcomes in addressing the state priority areas such as reducing teen pregnancy; promoting youth development and improving physical activity and nutrition are the NJ Personal Responsibility Education Program (NJ PREP), a school- and community-based comprehensive sexual health education program that replicates evidence-based and medically accurate programs proven effective in reducing sexual risk behaviors such as unprotected sex, or in encouraging safer ones, such as abstinence, using condoms and other methods of practicing safer sex. And the New Jersey Abstinence Education Program (NJ AEP), providing 10– to 14-year-old adolescents with the knowledge and skills to abstain from or delay the initiation of sexual activity and make healthy decisions and positive choices.

To address the obesity epidemic, the ShapingNJ Partnership continues to grow, and currently boasts more than 320 organizations that have signed a formal agreement with ShapingNJ, committing to work to implement 10 obesity prevention strategies throughout the state.

To improve access to health services, the NJDOH has provided reimbursement for uninsured primary medical and dental health encounters through the designated Federally Qualified Health Centers (FQHCs). In SFY 2016 the State is funding the FQHCs with $32.3 million to continue to focus on the needs of the uninsured and particularly those residents not eligible for the Patient Protection and Affordable Care Act (ACA) and/or NJ FamilyCare under Medicaid Expansion who need access to care and meet eligibility requirements.

In the area of children and youth with special health care needs (CYSHCN), the Newborn Screening and Genetic Services (NSGS) Program is helping to ensure that all newborns and families affected by an abnormal screening result receive timely and appropriate follow-up services. NJ newborns currently receive screening for 55 disorders. On June 30, 2014 screening for Severe Combined Immunodeficiency (SCID) was implemented and by end of 2016, implementation of screening for five lysosomal storage disorders will be implemented. NJ remains among the leading states in offering the most screenings for newborns. In addition to disorders detected through heel-stick, NJ's newborns are also screened with pulse oximetry through the Critical Congenital Heart Defects (CCHD) screening program. As of December 2015, DOH has received reports of 20 infants with previously unsuspected CCHDs screening detected through the screening program.

The Early Hearing Detection and Intervention (EHDI) Program monitors compliance with the NJ universal newborn hearing screening law and measures NJ's progress in achieving the national EHDI goals. The program continues working to improve rates of follow-up for children who refer on inpatient screening using a Plan-Do-Study-Act (PDSA) model of quality improvement.

Given the high rates of autism reported in NJ, FHS implemented the Birth Defects and Autism Reporting System (BDARS) in 2009. BDARS is a tool for surveillance, needs assessment, service planning, research, and most importantly for linking families to services. The BDARS, at present, refers all living children and their families to the Special Child Health Services Case Management Units (SCHS CMUs), which are within the Family Centered Care Services (FCCS) Program.

The FCCS program promotes access to care through early identification, referral to community-based culturally competent services and follow-up for CYSHCN age birth to 21 years of age. Ultimately, services and supports provided through Special Child Health Services Case Management Units (SCHS CMUs), Family WRAP (Wisdom, Resources, and Parent to Parent), and Specialized Pediatric Services Providers

(SPSP) via Child Evaluation Centers (CECs), Cleft Lip/Palate Craniofacial, and Tertiary Care Services are constructs that support NJ's efforts to address the six MCH Core Outcomes for CYSHCN. This safety net is supported by State and Title V funds administered via community health service grants, local support by the County Boards of Chosen Freeholders, reimbursement for direct service provision, and technical assistance to grantees. Through our Title V program partners, FHS continues to address families' social conditions by providing, in addition to quality health care, referrals to support services such as public health insurance options, legal services, food stamps, WIC, employment and public assistance. These are critically important to improve health outcomes and decrease the need for drugs or other medical interventions, improve quality, and reduce costs.

In 2014, CMU staffs launched a quality improvement (QI) project to enhance consistency in documentation within individual service plans across the SCHS CMUs, and to improve upon the Case Management Referral System's (CMRS) data gathering capability. Information garnered from this initiative is anticipated to enhance NJ's efforts to improve performance on the six core MCHB outcomes for CYSHCN. FCCS staffs presented QI findings to SCHS CMUs in June 2015. However, reconfiguring data reporting and tracking systems, as well as training and retraining State and community-based agencies, while keeping the needs of CYSHCN and their families center to our mission is a challenge. Technical assistance is provided to grantees to support small increments of change via the following modalities; face-face site visits, e-mails, conference calls and webinars, formal presentations at the SCHS Coordinator and quarterly meetings, and written guidance.

The reorganization of State services and supports for CYSHCN by our intergovernmental partners provided an opportunity to realign pathways for families and providers to access a continuum of care across the lifespan. Concurrently, the Affordable Care Act's assurances pose challenges as well as benefits for families with CYSHCN to maintain and optimize access to community-based care. These exciting changes are anticipated to broaden health insurance access. NJ's Title V CYSHCN program diligently collaborates with intergovernmental and community-based partners to ensure that care through these multiple systems will be coordinated, family centered, community-based, and culturally competent. Communication across State agencies and timely training for State staffs, community-based organizations and families with CYSHCN remains a priority to ensure that families are adequately supported during the reorganization of these systems.

Family input is centric to development and evaluation of FCCS programs. In 2015, the Title V program initiated family satisfaction surveys in English and Spanish. Over 800 responses were received and nearly 150 respondents completed their open ended questions in Spanish. In 2016, results will be shared with provider agencies, and used in review and planning for services. To date, 82% of the 18 participating agencies have submitted family satisfaction surveys for State office review and analysis. Data is being cleaned and tabulated at the State office, and upon receipt of the remaining surveys a final report is anticipated to be prepared in the fall 2016. Findings from the family satisfaction surveys should indicate areas for further investigation and quality improvement. Additionally, family and youth input on multi-system access to care is obtained through the Community of Care Consortium, a coalition led by Statewide Parent Advocacy Network, a key partner to NJ's Title V program and comprised of parents of CYSHCN and youth, State agency representatives, and community-based organizations.

In 2015, the Department received a 2-year/$300,000 HRSA State Implementation Grant for Enhancing the System of Services for CYSHCN through Systems Integration D-70 grant opportunity. This project enhances New Jersey's capacity to improve upon the proportion of CYSCHN who receive integrated care through a patient-centered medical home or health home approach. Working in collaboration with community partners including the NJ Academy of Pediatrics/Pediatric Council on Research and Education (NJ AAP/PCORE), the Statewide Parent Advocacy Network (SPAN), NJ Medicaid and others, this initiative addresses access to a medical home through collaborative partnerships across agencies, organizations and programs, and the development of policy and programs to ensure CYSHCN receive the comprehensive services and supports needed. As part of the overall arching goals of the project the partnerships foster (1) development of a shared resource, (2) integration of care for CYSHCN with the goal of working towards creating a comprehensive system of care for CYSHCN, and (3) a strategy to improve cross-system care coordination.

In sum, NJ is actively working on ways to improve outcomes while simultaneously celebrating some already achieved improvements, to the benefit of the women and children served as a result of the strong partnership between the State and the MCH Bureau.

II. Components of the Application/Annual Report

II.A. State Overview

The Maternal and Child Health Block Grant Application and Annual Report, submitted annually to the Maternal Child Health Bureau (MCHB), provides an overview of initiatives, State-supported programs, and other State-based responses designed to address the maternal and child health (MCH) needs in New Jersey. The Division of Family Health Services (FHS) in the New Jersey Department of Health (NJDOH), Public Health Services Branch posts a draft of the MCH Block Grant Application and Annual Report narrative to its website in the second quarter of each calendar year to receive feedback from the maternal and child health community.

The mission of the Division of Family Health Services (FHS) is to improve the health, safety, and well-being of families and communities in New Jersey. The Division works to promote and protect the health of mothers, children, adolescents, and at-risk populations, and to reduce disparities in health outcomes by ensuring access to quality comprehensive care. Our ultimate goals are to enhance the quality of life for each person, family, and community, and to make an investment in the health of future generations.

A brief overview of New Jersey demographics is included to provide a background for the maternal and child health needs of the State. While New Jersey is the most urbanized and densely populated state in the nation with 8.9 million residents, it has no single very large city. Only six municipalities have more than 100,000 residents.

New Jersey is one of the most racially and ethnically diverse states in the country. According to the 2014 New Jersey Population Estimates, 73.0% of the population was white, 14.8% was black, 9.4% was Asian, 0.6% was American Indian and Alaska Native, and 2.1% reported two or more races. In terms of ethnicity, 18.9% of the population was Hispanic. The racial and ethnic mix for New Jersey mothers, infants, and children is more diverse than the overall population composition. In 2013, 26.9% of mothers delivering infants in New Jersey were Hispanic, 45.6% were white non-Hispanic, 14.8% were black non-Hispanic, and 10.9% were Asian or Pacific Islanders non-Hispanic. The growing diversity of New Jersey's maternal and child population raises the importance of addressing disparities in health outcomes and improving services to individuals with diverse backgrounds.

Maternal and child health priorities continue to be a focus for the NJDOH. The Division of FHS, the Title V agency in New Jersey, has identified 1) improving access to health services thru partnerships and collaboration, 2) reducing disparities in health outcomes across the life span, and 3) increasing cultural competency of services as three priority goals for the MCH population. These goals are consistent with the Life Course Perspective which proposes that an inter-related web of social, economic, environmental, and physiological factors contribute in varying degrees through the course of a person's life and across generations, to good health and well-being.

The selection of the New Jersey's eight State Priority Needs is a product of FHS's continuous needs assessment. Influenced by the MCH Block Grant needs assessment process, the NJDOH budget process, the New Jersey State Health Assessment Plan, Healthy New Jersey 2020, Community Health Improvement Plans and the collaborative process with other MCH partners, FHS has selected the following State Priority Needs (see Section II.C. State Selected Priorities):
#1) Increasing Healthy Births,
#2) Improving Nutrition & Physical Activity,
#3) Reducing Black Infant Mortality,

#4) Promoting Youth Development,
#5) Improving Access to Quality Care for CYSHCN,
#6) Reducing Teen Pregnancy,
#7) Improving & Integrating Information Systems, and
#8) Smoking Prevention.

These goals and State Priority Needs (SPNs) are consistent with the findings of the Five-Year Needs Assessment and are built upon the work of prior MCH Block Grant Applications/Annual reports. Consistent with federal guidelines from the MCH Bureau, Title V services within FHS will continue to support enabling services, population-based preventive services, and infrastructure services to meet the health of all New Jersey's families. During a period of economic hardship and federal funding uncertainty, challenges persist in promoting access to services, reducing racial and ethnic disparities, and improving cultural competency of health care providers and culturally appropriate services.

Based on NJ's eight selected SPNs as identified in the Five-Year Needs Assessment, NJ has selected the following ten of 15 possible National Performance Measures (NPMs) for programmatic emphasis over the next five-year reporting period:
NPM #1 Well woman care,
NPM #4 Breastfeeding,
NPM #5 Safe Sleep,
NPM #6 Developmental Screening,
NPM #8 Physical activity,
NPM #10 Adolescent Preventive Medical Visit
NPM #11 Medical Home,
NPM #12 Transitioning to Adulthood,
NPM #13 Oral Health, and
NPM #14 Household Smoking.

State Performance Measures (SPM) have been reassessed through the needs assessment process. Five existing SPMs will be kept, and two old SPMs will be deleted. The existing SPMs which will be continued are: SPM #1 Black non-Hispanic Preterm Infants in NJ, SPM #2 Children with Elevated Blood Lead Levels, SPM #3 Hearing Screening Follow-up, SPM #4 Referral from BDARS to Case Management Unit, and SPM #5 Age of Reporting Autism to the BDARS. The old SPMs to be discontinued and replaced are: Regional MCH Consortia Implementing Community-based FIMR Teams and Overweight High School Students.

Table 1 - Title V MCH Block Grant Five-Year Needs Assessment Framework Logic Model (See Supporting Document #1) summarizes the selected ten NPMs and aligns the impact of Evidence-Based Informed Strategy Measures (ESMs) on NPMs and National Outcome Measures (NOMs). The purpose of the ESMs is to identify state Title V program efforts which can contribute to improved performance relative to the selected NPMs. The Logic Model is organized with one NPM per row. The Logic Model is the key representation which summarizes the Five-Year Needs Assessment process and includes the three-tiered performance measurement system with Evidence-Based or Informed Strategy Measures (ESM), National Performance Measures (NPM), and National Outcome Measures (NOMs). The Logic Model represents a more integrated system created by the three-tiered performance measure framework which ties the ESMs to the NPMs which in turn influence the NOMs.

The following is a brief overview of MCH services to put into context the Title V program within the State's health care delivery environment. The Improving Pregnancy Outcomes (IPO) Initiative grants were awarded in 2014 by Reproductive and Perinatal Health Services (RPHS) through a request for proposals (RFP) process. The IPO Initiative which promotes a Life Course perspective targets limited public health resources to communities with the highest need to improve quality access to prenatal care, preconception and interconception care as a means to decrease infant mortality rates. Using two models, Community Health Workers (CHW) and Central Intake (CI), the IPO Initiative will work to improve maternal and infant health outcomes including preconception care, prenatal care, interconceptual care, preterm birth, low

birth weight, and infant mortality through implementation of evidence-based and best practice strategies across three key life course stages: preconception, prenatal/postpartum and interconception.

The Community Health Worker (CHW) model performs outreach and client recruitment within the targeted community to identify and enroll women and their families in appropriate care. The second model is Central Intake (CI) which is a single point of entry for screening and referral of women of reproductive age and their families to necessary medical and social services. Central Intake works closely with community providers and partners, including CHWs, to eliminate duplication of effort and services. Standardized screening tools are used and referrals to programs and services are tracked in a centralized web-based system (SPECT – single point of entry and client tracking).

New Jersey was awarded the opportunity in 2014 to participate in the National Governors Association (NGA) Center for Best Practices' Learning Network on Improving Birth Outcomes (NGA IBO) Initiative. This initiative enabled NJ to explore evidence-based strategies shown to be effective in addressing poor birth outcomes. Participation in this NGA Learning Network afforded the NJDOH the opportunity to hold an in-state meeting on January 13, 2014 to explore these critical issues and to set the agenda for the future. The meeting of public and private partners provided a wider awareness of NJ's prematurity rates and other related maternal and child health indicators and discussed the steps necessary to further move the needle on these important health indicators.

In 2014 NJDOH was also invited to participate in the Infant Mortality Collaborative Improvement and Innovation Networks (IM CoIIN) sponsored by the MCH Bureau with technical assistance from the National Institute for Children's Health Quality. IM CoIIN is a state-driven HRSA-coordinated partnership to accelerate improvements in infant mortality by helping states: 1) innovate and improve their approaches to reducing infant mortality and improving birth outcomes through communication and sharing across state lines; and 2) use the science of quality improvement and collaborative learning to improve birth outcomes. The IM CoIIN State Team from NJ identified two priority areas - improving maternal postpartum visit rates and smoking cessation. The NGA IBO Initiative workgroups will continue as the IM CoIIN Strategy Teams to develop recommendations for improving birth outcomes and preventing infant mortality.

Another program promoting the Life Course Perspective is the Maternal and Infant Early Child Home Visiting (MIECHV) Program which has expanded Home Visiting across all 21 NJ counties with 6,857 families participating in HV during SFY 2014 (7/1/2014 to 6/30/2015). The goal of the NJ MIECHV Program is to expand NJ's existing system of home visiting services which provides evidence-based family support services to: improve family functioning; prevent child abuse and neglect; and promote child health, safety, development and school readiness. Full implementation of the NJ MIECHV Program is being carried out in collaboration with the Department of Children and Families (DCF) and is promoting a system of care of early childhood (see Support Document #5). NJ is a recipient of both a federal MIECHV Formula and Competitive grant.

The Child and Adolescent Health Program (CAHP) successfully applied in 2010 for two new federal grants to prevent teen pregnancy and promote youth development. In February and March, 2016, the NJ DOH submitted formula grant applications for federal fiscal year 2016 and 2017 for both teen pregnancy prevention programs. The New Jersey Abstinence Education Program (NJ AEP) will enable the state to continue the success of the last five years of implementing evidence-informed curricula to abstain or delay sexual activity, reduce pregnancy and STDs/STIs and, where appropriate, provides options that may include mentoring, counseling and/or adult supervision. NJ AEP expects more of its program participants to be in the younger age category of 10-14 than 15-19 years, but expanding the service level to 19 allows for continued educational reinforcement of the sexual risk avoidance (SRA) message at later developmental stages when teens are especially vulnerable to societal and peer expectations and influences. The new two-year funding opportunity will help New Jersey to continue implementing the NJ AEP. New Jersey will be funded in the amount of $1,486,335 for the project and budget period of October 1, 2015 through September 30, 2017. The NJ Personal Responsibility Education Program (NJ PREP) is a school- and community-based comprehensive sexual health education program that replicates evidence-based and medically accurate programs proven effective in reducing sexual risk behaviors such as

unprotected sex, or in encouraging safer ones, such as abstinence, using condoms and other methods of practicing safer sex. NJ PREP also provides education on at least three of the following adult preparation topics: healthy relationships; positive adolescent development; financial literacy; parent-child communication skills; education and employment preparation skills and healthy life skills. The new two-year funding cycle FFY 2016 and FFY 2017 will enable the state to continue the success of the last five years in replicating evidence-based programs (EBPs) to help youth, ages 10-21, delay sexual activity, increase condom or contraceptive use among sexually active youth, and reduce pregnancy and STDs/STIs through September 30, 2019. New Jersey is scheduled to receive $1,423,244 in PREP grant funds for FFY 2016 (SFY2018). As an expansion to the current population being served, both NJ AEP and NJ PREP grantees will outreach to especially vulnerable populations including youth: in or aging out of foster care, homeless youth, youth with HIV/AIDS, pregnant youth under 21 years of age, mothers who are under 21 years of age, and youth residing in areas with relatively high birth rates compared to all youth within the state.

The goal of the second program, New Jersey Abstinence Education Program (NJ AEP), is to provide 10– to 14-year-old adolescents with the knowledge and skills to abstain from or delay the initiation of sexual activity. At least 50% of these youth live in one of the 30 state-identified, high-risk NJ municipalities. NJ AEP helps teens make healthy decisions and positive choices to meet their future life goals. NJ AEP has been implemented in eight NJ counties including in 60 public schools, and in nine community-based and 11 faith-based settings, reaching more than 8,000 10- to 14-year-olds annually.

To address the obesity epidemic, the ShapingNJ Partnership continues to grow, and currently boasts more than 230 organizations that have signed a formal agreement with ShapingNJ, committing to work to implement 10 obesity prevention strategies throughout the state. The goal of the ShapingNJ Partnership is to prevent obesity and improve the health of populations that are at risk for poor health outcomes in NJ by making "the healthy choice, the easy choice." The ShapingNJ website reaches consumers as well as professionals and partners with the latest research, information and best practices, as well as toolkits for improving health in each of the 6 settings where New Jerseyans live, work and play: child care centers, schools, communities, worksites and businesses, and healthcare settings.

To improve access to health services, the NJDOH has provided reimbursement for uninsured primary medical and dental health encounters through the designated Federally Qualified Health Centers (FQHCs) since 1992 under the Federally Qualified Health Centers-Uncompensated Care Fund.

In SFY 2015, the FQHC–Uncompensated Care Fund was funded at $31.5 million. In SFY 2016, the FQHC–Uncompensated Care Fund was funded at $32.3 million. NJ recently added 1 new licensed FQHC, four licensed ambulatory primary care site, 2 new FQHCs are pending approval and 1 additional site is pending approval - bringing the total number of licensed sites to 110. In SFY 2017 the FQHC–Uncompensated Care Fund proposed funding is $28 million.

In the area of children and youth with special health care needs (CYSHCN), the Newborn Screening and Genetic Services Program (NSGS) helps to ensure that all newborns and families affected by an abnormal screening result will receive timely and appropriate follow-up services. In terms of newborn screening for disorders detectable via the heelstick, all newborns receive screening for 55 disorders. On June 30, 2014 screening for Severe Combined Immunodeficiency (SCID) was implemented and by end of 2016, implementation of screening for five lysosomal storage disorders including Krabbe, Pompe, Neimann Pick, Fabry, and Gaucher, will be implemented. Follow-up services include notification and communication with parents, primary care physicians, pediatric specialists and others to ensure the baby has immediate access to confirmatory testing and treatment. In State Fiscal Year 2015, 99,092 newborns received initial screens and 6,149 infants had abnormal screening results. New Jersey remains among the leading states in offering the most screenings for newborns.

NSGS meets and communicates regularly with several advisory panels composed of parents, physicians, specialists, and others to ensure NJ's program is state-of-the-art in terms of screening technologies and operations and it is responsive to any current concerns regarding newborn screening.

Legislation mandating newborn pulse oximetry screening to detect Critical Congenital Heart Defects (CCHD) took effect on August 31, 2011. Aggregate and individual level data reporting mechanisms were implemented to ensure that all eligible births are screened. Through December 2015, NJ birthing facilities submitted quarterly aggregate screening reports. Aggregate reporting has since been discontinued with the inclusion of pulse ox screening questions in the new web-based Electronic Birth Registry System affording the capability to track individual level screening results. In addition, information on all infants with failed screens is reported by each birthing facility to the Birth Defects Registry via the Pulse Oximetry Module. As of December 2015, NJDOH has received reports of 20 infants with previously unsuspected critical congenital heart defects detected through the screening program. In 2012, NJ was one of six states awarded a 3-year HRSA funded CCHD Newborn Screening Demonstration Program Grant which has enabled the development of education for parents, nurses, and physicians regarding CCHD and screening. New Jersey received a no cost extension of this program grant through February 2016. Collaboration with the NJ Chapter of the American Academy of Pediatrics is currently underway to continue the activities of the program. NJDOH continues to provide technical assistance to the birthing facilities and, in 2016, in partnership with the NJ neonatal intensive care unit (NICU) Collaborative, led a multi-state evaluation of screening practices in the NICU. Twenty-one NICUs in five states (CA, IL, MN, NJ, NY) participated in the evaluation. Final results may influence local, state and national screening practices in the NICU and will be used to assess the need for administrative rules in NJ regarding screening this population.

The Early Hearing Detection and Intervention Program (EHDI) monitors compliance with the NJ universal newborn hearing screening law, and measures NJ's progress in achieving the national EHDI goals of ensuring that all infants receive a hearing screening by one month of age, that children who do not pass screening receive diagnostic testing by three months of age, and that children who are diagnosed with hearing loss receive family-centered, culturally competent Early Intervention Services by six months of age. Hospitals have been very successful in ensuring that newborns receive hearing screening prior to hospital discharge, ensuring that children who did not pass their initial screening receive timely and appropriate follow-up remains an area for continued efforts.

The NJ EHDI Program is working with hospitals, audiologists and physicians to identify "small tests of change" to identify successful strategies for improving outpatient follow-up rates for infants that did not pass initial screening.

NJ continues to have one of the highest rates of autism in the United States. According to the Centers for Disease Control and Prevention's (CDC) 2012 prevalence figures published in the Morbidity and Mortality Weekly Report (MMWR) on March 31, 2016, cited NJ as having the highest prevalence rate of 24.6 per 1,000, or approximately one in 41. These most recent statistics were based on studies from four counties in NJ.

The Governor's Council for Medical Research and Treatment of Autism (the Council) is in the Office of the Commissioner at NJDOH; the Council has 14 members and is legislatively mandated. In 2012, the Council established a Center of Excellence for Autism (NJACE). The mission of the NJACE is to research, apply and advance best practices in the understanding, prevention, evaluation and treatment of autism spectrum disorders (ASDs), enhancing the lives of individuals with ASDs across their lifespans. The NJACE consists of (1) a Coordinating Center, Clinical Research Program Sites, and multiple clinical Research Pilot Projects, including 3 Medical Home Pilots. The NJACE consists of (1) a Coordinating Center, (2) Clinical Research Program Sites, and (3) Clinical Research Pilot Projects. The NJ ACE Coordinating Center provides common management and support functions to unify the NJ ACE Clinical Research Program Sites and Pilot Project grantees, increase efficiency and reduce costs. The five-year Coordinating Center grant was awarded to Montclair State University. The NJ ACE Program Site and Pilot Project grantees will develop and conduct clinical research projects with the potential to improve the physical and/or behavioral health and well-being of individuals with ASDs. The Council is particularly interested in projects with potential direct clinical impact and those that address issues across the lifespan.

On July 1, 2009, the Early Identification and Monitoring (EIM) Program implemented the Birth Defects and Autism Reporting System (BDARS). BDARS is an invaluable tool for surveillance, needs assessment, service planning, research, and most importantly for linking families to services. NJ has the oldest requirement in the nation for the reporting of birth defects, starting in 1928. Since 1985, NJ has maintained a population-based birth defects registry of children with all defects. Starting in 2003, the Registry received a CDC cooperative agreement for the implementation of a web-based data reporting and tracking system. In 2007, NJ passed legislation mandating the reporting of Autism. Subsequently, with the adoption of legislative rules in September 2009, the Registry added the Autism Spectrum Disorders (ASD) as reportable diagnoses and the Registry was renamed the Birth Defects and Autism Reporting System (BDARS), expanded the mandatory reporting age for children diagnosed with birth defects to age 6, and added severe hyperbilirubinemia as a reportable condition if the level is 25mg/dl or greater. The BDARS, at present, refers all living children and their families to the Special Child Health Services Case Management Units (SCHS CMUs), which are within the Family Centered Care Services Program.

New Jersey has been very successful in linking children registered with the BDARS with services offered through the county-based SCHS CMUs. However, the system did not further track children and families to determine if and what services were offered to any of the registered children. Added in 2012, the Case Management Referral System (CMRS) is used by the CMUs to track and monitor services provided to the children and their families. It electronically notifies a CMU when a child living within their county has been registered. Also included in CMRS is the ability to create and modify an Individual Service Plan (ISP), track services, create a record of each contact with the child and child's family, create standardized quarterly reports and other reports, and register previously unregistered children.

CMRS was successfully adopted by all 21 counties and is live statewide. It provides the State Title V program with the opportunity for desk top review of referral and linkage to care. As existing cases are migrated to CMRS, and newly referred cases are entered into the database, it is anticipated that trends in access to care and outcomes will be more measurable and readily tracked. Likewise, the challenges of reconfiguring data reporting and tracking systems, as well as the training and retraining State and community-based agencies, while keeping the needs of CYSHCN and their families center to our mission is our challenge.

The Family Centered Care Services (FCCS) program promotes access to care through early identification, referral to community-based culturally competent services and follow-up for CSYHCN age birth to 21 years of age. Ultimately, services and supports provided through Special Child Health Services Case Management Units (SCHS CMUs), Family WRAP (Wisdom, Resources, and Parent to Parent), and Specialized Pediatric Services providers (SPSP) via Child Evaluation Centers (CECs), Cleft Lip/Palate Craniofacial, and Tertiary Care Services are constructs that support NJ's efforts to address the six MCH Core Outcomes for CYSHCN. This safety net is supported by State and federal funds administered via community health services grants, local support by the County Boards of Chosen Freeholders, reimbursement for direct service provision, and technical assistance to grantees. Likewise, intergovernmental and interagency collaboration is ongoing among federal, State and community partners and families; i.e., Social Security Administration; NJ State Departments of Human Services' NJ FamilyCare/Medicaid programs, Catastrophic Illness in Children Relief Fund, Children and Families, Labor, Banking and Insurance, Boggs Center/Association of University Centers on Disabilities, NJ Council on Developmental Disabilities, and community-based organizations such as the NJ Academy of Pediatrics Pediatric Council on Research and Education (NJ PCORE), NJ Hospital Association, and disability specific organizations such as the Arc of NJ, and the Statewide Parent Advocacy Network (SPAN) and the Community of Care Consortium (COCC). Consultation and collaboration with NJDOH programs such as the Birth Defects and Autism Registry, Early Intervention System, the Ryan White Family Centered HIV Care Network, Maternal Child Health, Special Supplemental Nutrition Program for Women, Infants and Children, Primary Care/Federally Qualified Health Centers, and HIV/AIDS, STD, and Tuberculosis, as well as Public Health Infrastructure, Laboratories, and Emergency Preparedness affords FCCS with opportunities to communicate and partner in supporting CYSHCN and their families. For example, the transition of CYSHCN formerly enrolled in the Community Resources for Persons with Disabilities waiver and newly identified underinsured CYSHCN into Managed Long Term Services and

Supports, the referral of uninsured transition aged youth into Medicaid expansion or the Marketplace, and support for families affected by Superstorm Sandy are accomplished through interagency collaboration and linkage with resources across agencies and systems.

Family input is centric to development and evaluation of FCCS programs. In addition to the Press Ganey surveys administered by SPSP provider agencies, in 2015, the Title V program distributed family satisfaction surveys in English and Spanish. Over 800 responses were received and nearly 150 respondents completed their open ended questions in Spanish. Data is being cleaned and analyzed, will be shared with provider agencies, and used in review and planning for services. An example of preliminary data that will be helpful in planning services includes: 71% of parents whose children received services through the Child Evaluation Centers said that their coordination of services was excellent. Findings from the family satisfaction surveys should indicate areas for further investigation and quality improvement. Additionally, family and youth input on multi-system access to care is obtained through the COCC, a community coalition led by SPAN and comprised of parents of CYSHCN and youth, State agency representatives, and community-based organizations. COCC members and visitors meet quarterly and collaborate to improve access to share updates on federal, State, and community-based programs and services that address access to care for CYSHCN.

NJ remains successful in linking children registered with the Birth Defects and Autism Reporting System (BDARS) with services offered through the SCHS CMUs; CECs including the Fetal Alcohol Syndrome and Alcohol Related Neurodevelopmental Disorder (FAS/ARND) Centers; Cleft Lip/Palate Craniofacial Centers; Tertiary Care Centers; and Family WRAP. With CDC Surveillance grant funding, the system is undergoing enhancements to support tracking of CYSHCN referred to SCHS CM, and monitoring of services offered and/or provided to determine client outcomes. In 2014, State Case Management staffs launched a quality improvement project to enhance consistency in documentation within individual service plans across the SCHS CMUs, and to improve upon the Case Management Referral System's (CMRS) data gathering capability. FCCS staffs presented QI findings to SCHS CMUs in June 2015. Information garnered from this initiative is anticipated to enhance NJ's efforts to improve performance on the six core MCHB outcomes for CYSHCN.

The reorganization of State services and supports for CYSHCN by intergovernmental partners; Department of Human Services; Division of Medicaid and Health Services and Division of Developmental Disabilities; the Department of Children and Families' Divisions of Children's System of Care and Division of Family and Community Partnerships, and the Department of Health's Division of Aging and Community Services realigned pathways for families and providers to access a continuum of care across the lifespan. Concurrently, the Affordable Care Act's assurances pose challenges and benefits for families with CYSHCN to maintain and optimize access to community-based care. These exciting changes are anticipated to broaden health insurance access. NJ's Title V CYSHCN program diligently collaborates with intergovernmental and community-based partners to ensure that care through these multiple systems will be coordinated, family centered, community-based, and culturally competent. Communication across State agencies and timely training for State staffs, community-based organizations and families with CYSHCN remains key to ensuring that families are adequately supported during the reorganization of these systems.

In addition to the health care system changes described above, in 2012 the extremely dangerous and damaging Superstorm Sandy (SSS) affected NJ CYSHCN and their families. Significant recovery has been achieved. However, its catastrophic effects challenged our State's infrastructure and ability to maintain an integrated safety net of providers, mobilize and share resources, as well as to support evacuation, re-location and long-term recovery. It also provided opportunities for the Title V program to promote resiliency for CYSHCN and their families by providing information, training, referral and supports to families, as well as technical support to colleagues in federal, State and local agencies. Through June 30, 2015, enhanced capacity for the provision of case management and family support will continue for Sandy-impacted families of CYSHCN that reside in 10 coastal counties through Social Services Block Grant funding. Transition planning for CYSHCN was completed June 2015 to ensure continuity of supports with their SCHS CMU and long-term recovery groups. These efforts will be described more fully in State Agency Coordination.

II.B. Five-Year Needs Assessment Summary

II.B.1. Process

The New Jersey Title V program, the Division of Family Health Services (FHS), has prepared the following Five-Year Needs Assessment Summary that identifies consistent with health status goals and national health objectives the need for: preventive and primary care services for pregnant women, mothers and infants; preventive and primary care services for children; and services for children and youth with special health care needs (CYSHCN). NJ has prepared this statewide Five-Year Needs Assessment Summary according to Title V guidelines.

The completion of a comprehensive needs assessment for the Maternal and Child Health (MCH) population groups is a continual process that the FHS performs in collaboration with many other organizations and partners. The needs assessment process is consistent with the conceptual framework in Figure 1 MCH Needs Assessment, Planning, Implementation, and Monitoring Process in the guidance. The ultimate goals of the needs assessment process are to strengthen partnerships and collaboration efforts within FHS, the New Jersey Department of Health (NJDOH), the MCH Bureau, and other agencies and organizations involved with MCH and to improve outcomes for the MCH populations.

The goals and vision that guide the Needs Assessment originate from the mission statement of the Division of Family Health Services (FHS). Leadership for directing and completing a comprehensive needs assessment is provided by the Assistant Commissioner of FHS, Service Directors in FHS, and the Program Managers in FHS. The overall needs assessment methodology is similar for each of the three population groups - preventive and primary care services for pregnant women, mothers and infants; preventive and primary care services for children; and services for children with special health care needs. Though many of the functions occur simultaneously the sequential process is described below. This is a continuous and on-going process throughout the year.

II.B.2. Findings

The selection of the New Jersey's eight State Priority Needs (SPNs) is a product of FHS's continuous needs assessment. Multiple processes contribute to the overall needs assessment process including: the MCH Block Grants needs assessment process, the NJ State Health Assessment process, the NJDOH budget process, Departmental strategic planning, assessment of the Healthy New Jersey 2020 objectives, the Public Health accreditation process, the NJ Preventive Health and Health Services Block Grant, Community Health Improvement Plans, grant-driven needs assessments (MIECHV, Healthy Start, PREP…), public comment on the MCH Block Grant Application, and the collaborative process with other MCH partners. As a result of the overall needs assessment process, FHS has selected the following State Priority Needs for the MCH Block Grant (see Section II.C. State Selected Priorities):
SPN #1) Increasing Healthy Births,
SPN #2) Improving Nutrition & Physical Activity,
SPN #3) Reducing Black Infant Mortality,
SPN #4) Promoting Youth Development Programs,
SPN #5) Improving Access to Quality Care for CYSHCN,
SPN #6) Reducing Teen Pregnancy,
SPN #7) Improving & Integrating Information Systems, and
SPN #8) Smoking Prevention.

Some of these priorities have been longstanding priorities (SPN #3 Decreasing Black Infant Mortality, SPN #6 Decreasing Teen Pregnancy, SPN #7 Improving and Integrating Information Systems, and SPN #5 Improving Access to Quality Care for CSHCN). Others are priorities that broadly address several areas or population groups (SPN #4 Promoting Youth Development Programs, SPN #1 Increase Healthy Births, and SPN #8 Smoking Prevention). A priority focusing attention on the more recent public health issues of obesity is SPN #2 Improving Nutrition and Physical Fitness. The selected SPN reflect ongoing and new

statewide public health initiatives. SPN #1 has been a recent focus of several new initiatives including the Improving pregnancy Outcomes Initiative, the NGA Improving Birth Outcomes, the IM CoIIN and the MIEC Home Visiting Program.

Based on NJ's eight selected SPNs as identified in the Five-Year Needs Assessment, NJ has selected the following ten of 15 possible National Performance Measures (NPMs) for programmatic emphasis over the next five-year reporting period:
NPM #1 Well woman care,
NPM #4 Breastfeeding,
NPM #5 Safe Sleep,
NPM #6 Developmental Screening,
NPM #8 Physical activity,
NPM #10 Adolescent Preventive Medical Visit
NPM #11 Medical Home,
NPM #12 Transitioning to Adulthood,
NPM #13 Oral Health, and
NPM #14 Household Smoking.

State Performance Measures (SPM) have been reassessed through the needs assessment process. Five existing SPMs will be kept, and two old SPMs will be deleted. The existing SPMs which will be continued are: SPM #1 Black non-Hispanic Preterm Infants in NJ, SPM #2 Children with Elevated Blood Lead Levels, SPM #3 Hearing Screening Follow-up, SPM #4 Referral from BDARS to Case Management Unit, and SPM #5 Age of Reporting Autism to the BDARS. The old SPMs to be deleted are: Regional MCH Consortia Implementing Community-based FIMR Teams and Overweight High School Students.

Table 1a - Title V MCH Block Grant Five-Year Needs Assessment Framework Logic Model (See Supporting Document #1) summarizes the selected ten NPMs and aligns the impact of Evidence-Based Informed Strategy Measures (ESMs) on NPMs and National Outcome Measures (NOMs). The purpose of the ESMs is to identify state Title V program efforts which can contribute to improved performance relative to the selected NPMs. The Logic Model is organized with one NPM per row. The Logic Model is the key representation which summarizes the Five-Year Needs Assessment process and includes the three-tiered performance measurement system with Evidence-Based or Informed Strategy Measures (ESM), National Performance Measures (NPM), and National Outcome Measures (NOMs). The Logic Model represents a more integrated system created by the three-tiered performance measure framework which ties the ESMs to the NPMs which in turn influence the NOMs.

As required in the first year Application/Annual Report (FY 2016/FY 2014), **Table 1b** - Findings of the Five-Year State Needs Assessment (See Supporting Document #1) presents a focused summary of the findings of its Five-year Needs Assessment. The following table, Findings of the Five-Year Needs Assessment, provides this summary in tabular form. Highlighted in this summary are the health status of the MCH population (indicated as improving ↑, unchanged ↔, or worsening ↓) relative to the state's noted MCH strengths/*needs* and the identified national MCH priority areas, organized and presented by each of the six population health domains. Also summarized are the adequacy and *limitations* of the NJ Title V program capacity and partnership building efforts relative to addressing the identified MCH population groups and program needs. Specific partnership and collaborative efforts are listed, along with descriptions of promotion of family/consumer engagement and leadership, coordination with other MCHB and federal, state and local MCH investments.

II.B.2a. MCH Population Needs

Table 1c - Summary of MCH Population Needs (See Supporting Document #1) displays the health status for each of the six population health domains according to the 10 selected NPMs. The table provides a summary of population-specific strengths/needs and identifies major health issues for each of the 6

population health domains which came from identified successes, challenges, gaps and areas of disparity identified during the needs assessment process.

II.B.2b. Title V Program Capacity

II.B.2b.i. Organizational Structure

All Maternal and Child Health (MCH) programs including programs for Children and Youth with Special Health Care Needs (CYSHCN) are organizationally located within the Division of Family Health Services (FHS). All Title V services are under the direction of Gloria Rodriguez, Assistant Commissioner, Division of FHS.

See attached Supporting Document #2 for organizational charts of NJDOH, FHS, MCHS and SCHEIS.

II.B.2b. ii Agency Capacity

This section describes Family Health Service's capacity to promote and protect the health of all mothers and children, including children and youth with special health care needs (CYSHCN). The Maternal and Child Health Services (MCHS) and Special Child Health and Early Intervention Services (SCHEIS) Units ensure a statewide system of services that reflect the principles of comprehensive, community-based, coordinated, family-centered care through collaboration with other agencies and private organizations and the coordination of health services with other services at the community level.

The mission of the Division of Family Health Services (FHS) is to improve the health, safety, and well-being of families and communities in New Jersey. The Division works to promote and protect the health of mothers, children, adolescents, and at-risk populations, and to reduce disparities in health outcomes by ensuring access to quality comprehensive care. Our ultimate goals are to enhance the quality of life for each person, family, and community, and to make an investment in the health of future generations.

The statutory basis for maternal and child health services in NJ originates from the statute passed in 1936 (L.1936, c.62, #1, p.157) authorizing the Department of Health to receive Title V funds for its existing maternal and child services. When the State constitution and statutes were revised in 1947, maternal and child health services were incorporated under the basic functions of the Department under Title 26:1A-37, which states that the Department shall "Administer and supervise a program of maternal and child health services, encourage and aid in coordinating local programs concerning maternal and infant hygiene, and aid in coordination of local programs concerning prenatal, and postnatal care, and may when requested by a local board of education, supervise the work of school nurses."

Other statutes exist to provide regulatory authority for Title V related services such as: services for children with Sickle Cell Anemia (N.J.S.A. 9:14B); the Newborn Screening Program services (N.J.S.A. 26:2-110, 26:2-111 and 26:2-111.1); genetic testing, counseling and treatment services (N.J.S.A. 26:5B-1 et. seq.,); services for children with hemophilia (N.J.S.A. 26:2-90); the birth defects registry (N.J.S.A. 26:8-40.2); the Catastrophic Illness in Children Relief Fund (P.L. 1987, C370); childhood lead poisoning prevention and screening (Title 26:2-130-137); and the Sudden Infant Death Syndrome (SIDS) Resource Center (Title 26:5d1-4). Recent updates to Title V related statutes are mentioned in their relevant sections.

Table 1d – Title V Program Capacity and Collaboration to Ensure a Statewide System of Services
(See Supporting Document #1) summarizes according to the six MCH population health domains the collaborations with other state agencies and private organizations, the state support for communities, the coordination with community-based systems, and the coordination of health services with other services

at the community level.

II.B.2b.ii. Preventive and Primary Care for Pregnant Women, Mothers and Infants

The mission of Maternal and Child Health Services (MCHS) within FHS is to improve the health status of New Jersey families, infants, children and adolescents in a culturally competent manner, with an emphasis on low-income and special populations. Prenatal care, reproductive health services, perinatal risk reduction services for women and their partners, postpartum depression, mortality review, child care, early childhood systems development, childhood lead poisoning prevention, immunization, oral health and hygiene, student health and wellness, nutrition and physical fitness and teen pregnancy prevention are all part of the MCHS effort. The population Domains addressed by MCHS include 1, 2, 3, 4, and 6.

Reproductive and Perinatal Health Services (RPHS), within MCHS, coordinates a regionalized system of care of mothers and children in collaboration with the Maternal and Child Health Consortia (MCHC). The MCHC were developed to promote the delivery of the highest quality of care to all pregnant women and newborns, to maximize utilization of highly trained perinatal personnel and intensive care facilities, and to promote a coordinated and cooperative prevention-oriented approach to perinatal services. Continuous quality improvement activities are coordinated on the regional level by the MCHC.

NJ successfully applied in 2010 for the Maternal, Infant and Early Childhood Home Visiting Program (MIEC HV) Formula and Competitive Grants to the Health Resources and Services Administration. The goal of the NJ MIEC HV Program is to expand NJ's existing system of home visiting services which provides evidence-based family support services to: improve family functioning; prevent child abuse and neglect; and promote child health, safety, development and school readiness. Full implementation of the grant project is being carried out in collaboration with the Department of Children and Families (DCF). Currently evidence-based home visitation services are provided by 67 Local Implementing Agencies (LIAs) providing three national models (Healthy Families America, Parents As Teachers and Nurse Family Partnership) in all 21 NJ counties serving approximately 6,000 families in SFY 2014.

II.B.2b.ii. Preventive and Primary Care for Children and Adolescents

The Child and Adolescent Health Program (CAHP), within MCHS, focuses on primary prevention strategies involving the three MCH domains of Child Health, Adolescent/Young Adult Health, and the Life Course.

An emphasis in Child Health is the prevention of lead poisoning among children under six years of age through collaborative, prevention-oriented outreach and education to parents, property owners, and health care providers. The Childhood Lead Poisoning Prevention (CLPP) Projects use a home visiting model to provide nurse case management and environmental investigations for children less than six years of age with confirmed elevated blood lead levels. Thirteen sites throughout the State receive funding to provide monitoring of retesting of elevated blood lead levels, to perform household education and conduct residential property inspections to identify and abate lead hazards. The goal of the CLPP Projects are to promote a coordinated support system for lead poisoned children and their families through the development of stronger linkages with Special Child Health Services, Medicaid Managed Care Organizations (MCOs), DCF, DOE, Department of Community Affairs, and community-based agencies that provide early childhood services.

Since July 2010, Adolescent Health has been working to implement the CDC Whole School, Whole Community, Whole Child (WSCC) model. One Full Time Equivalent (FTE) professional staff person is assigned responsibility for this project and the position is currently vacant. The CDC model provides a framework for organizing school health into 10 components: 1) Health Education, 2) Physical Education, 3) Health Services, 4) Counseling, Psychological and Social Services, 5) Nutrition Services, 6) Staff Wellness, 7) Healthy Physical School Environment, 8) Healthy Social-Emotional School Climate and Culture, 9) Family Engagement, and 10) Community Involvement. School health programs promote healthy behaviors and health is critically linked to academic performance. Self-reported health behaviors (alcohol, tobacco and other drug (ATOD) use; healthy food choices; physical activity; sexual activity; and,

violence, injury and safety) of high school youth are surveyed every other (odd numbered) year using the NJ Student Health Survey. In SFY2016, regional school health grantee agencies partnered with Sustainable Jersey for Schools (SJfS) through a MOA with the Sustainability Institute at the College of NJ (TCNJ). DOH funded 29 schools a total of $116,000 to implement one of nine health and wellness actions. Partnership opportunities with the School Health Leadership Institute at Rutgers and the NJ AAP and State School Nurses Association are anticipated for SFY2017.

The CAHP successfully applied for and was awarded two new federal grants to prevent teen pregnancy in 2010. The New Jersey Personal Responsibility Education Program (NJ PREP) enables six grantees to replicate evidence-based programs that have proven effectiveness in changing behaviors to delay sexual activity, increase condom or contraceptive use for sexually active youth, or reduce pregnancy among youth. NJ PREP funding also provides education on at least three of the following adult preparation topics: healthy relationships; positive adolescent development; financial literacy; parent-child communication skills; education and employment preparation skills and healthy life skills. NJ PREP grantees implement seven evidence-based sexual health education programs: Be Proud Be Responsible; Be Proud Be Responsible Be Protective; Making Proud Choices; Reducing the Risk; SiHLE; Teen Health Project; and Teen Outreach Program. In SFY 2016, NJ PREP was successfully implemented by six sub-grantees at more than 68 locations (24 community-based organizations and 44 school-based organizations) in 29 municipalities and 11 counties throughout the State to reach about 4,000 unduplicated youth participants.60 locations (27 community-based organizations and 34 school-based organizations) in 24 municipalities and 12 counties throughout NJ reaching approximately 2,300 unduplicated youth participants. In December 2015, the NJ DOH and the external evaluator completed the NJ PREP evaluation employing a quasi-experimental design, with intervention and control groups and surveys administered at baseline, post-test (after the program) and 3-month follow-up. The overall study population from August 2013-September 2015 for intervention and control groups N=5227 (2856 intervention, 54.6%; 2371 control, 45.4%). The post-test included N=4183 participants (observed at pre- and post-test, 80.0% of baseline). The follow-up included N=2733 participants (observed at pre- and follow-up tests, 52.3% of baseline). Basic demographics characteristics at baseline except for age and grade (intervention 15.3 (SD = 2.07) years; control 15.5 (SD = 2.00) years; $p < .001$) were similar. Overall, PREP participants realized significant improvements in sexual and reproductive health (SRH) outcomes compared to the control group at post-test in knowledge, intentions and behaviors. PREP grantees will continue to participate in the State-led external evaluation of NJ PREP for SFY 2018 and 2019. The evaluator will collect and analyze data and assess program effectiveness in achieving these outcomes: delay of sexual intercourse; increased use of condoms and contraception among sexually active youth; decreased frequency of sexual intercourse; a decrease in the number of sexual partners, and a decrease in unprotected sex. Additional measures being determined include and increases in: 1) knowledge of the identified APS topics; and, 2) specific youth development assets or protective factors needed for a healthy and productive adult life.

These six grantees, selected in 2011 using a Request for Applications (RFA) process, will be required to implement one of three EBPs: Be Proud, Be Responsible, Be Protective; Reducing the Risk; and Teen Outreach Program to achieve the NJ PREP goal in SFY 2018 and 2019. Program implementation will take place in public schools, community- and faith-based organizations. PREP grantees will also be required to: 1) use age- and culturally-appropriate and medically accurate curricula; 2) include evidence-informed curricula that address three of the six adult preparatory subjects: financial literacy, education/career success, and parent-child communication; and, 3) incorporate positive youth development strategies and utilize a trauma-informed framework to strengthen their programs. A Teen Pregnancy Prevention (TPP) Collaborating Group will be convened by the DOH's Teen Pregnancy Prevention Programs, PREP and the Abstinence Education Program (AEP), and external TPP stakeholders will be invited. The role of the TPP Collaborating Group will be to strengthen existing and outreach for new, partnerships and working to coordinate, integrate and link TPP programs with reproductive and related health- or social- services in the high-risk municipalities.

Four AEP grantees, selected in 2011 using a Request for Applications (RFA) process, will implement approved, medically accurate, age-appropriate curricula with regard to the developmental stage of the youth participant, incorporate PYD strategies and utilize a trauma-informed approach to achieve the NJ

AEP goal and strengthen current programs. Program implementation takes place in public schools, and community- and faith-based organizations. In SFY 16, NJ AEP is implemented in eight counties in New Jersey, in 51 public schools, and nine community-based and 11 faith-based settings, reaching more than 8,000 10 to 14-year- olds annually. NJ AEP grantees also undertook a pilot implementation of an evidence-based program, Teen Outreach Program (TOP), in collaboration with a NJ PREP grantee experienced in its replication. The current grant year includes an evaluation of this combined abstinence education and PYD approach which will be conducted by the ACT for Youth, Center of Excellence at Cornell University.

Both AEP and PREP grantees will also outreach to the population of young people who are significantly more likely than their peers to become a pregnant teen or to father a child as a teen. This population includes youth who are in or aging out of foster care or adjudication systems, expectant or parenting, and/or runaway and homeless.

The NJDOH established the NJ Children's Oral Health Program (COHP) in 1981. The program provides a variety of interactive, age-appropriate oral health education activities for children in grades K through 12. The Program is regionally implemented in the twenty-one counties of the State with each region having an Oral Health Coordinator and multi-disciplinary program staff that implement oral health activities. The oral health topics addressed include: good oral hygiene practices, fluoride as a preventive measure, dental sealants, healthy food choices, periodontal disease, tobacco cessation, prevention of oral injury and the importance of regular dental exams. Classroom presentations include interactive discussion and audio-visual presentations. All program activities are adaptable for children with special needs. Education initiatives are also conducted for parents, teen parents, Women, Infant, Children (WIC) clients and pregnant women. In-service and workshop programs for non-dental professionals, including school nurses, public health nurses, teachers, WIC Coordinators, multi-disciplinary obstetric and pediatric staff, social workers and nursing students are also conducted.

II.B.2b.ii. Preventive and Primary Care for Children with Special Health Care Needs

NJ maintains a comprehensive system to promote and support access to preventive and primary care for CYSHCN through early identification, linkage to care, and family support. Title V partially supports this safety net which is comprised of pediatric specialty and sub-specialty, case management, and family support agencies that provide in-state regionalized and/or county-based services. It is designed to provide family-centered, culturally competent, community-based services for CYSHCN age birth to 21 years of age, as well as to enhance access to medical home, facilitate transition to adult systems, and health insurance coverage. The Specialized Pediatric Services Programs (SPSP) agencies are a significant resource of pediatric specialty and subspecialty care in NJ, and are used widely by CYSHCN including Medicaid recipients. Although clients are screened for their ability to pay for clinical services, the support provided by Title V enables all CYSHCN to be served regardless of their ability to pay. There is no charge for SCHS CM and family support.

Section II.F.2. MCH Workforce Development and Capacity provides more detail on Family Health Service's capacity to promote and protect the health of all mothers and children, including children and youth with special health care needs (CYSHCN).

B.2b. iii MCH Workforce Development and Capacity

This section describes the strengths and needs of the state MCH and CSHCN workforce, including the number, location and full-time equivalents of state and local staff who work on behalf of the state Title V programs. Included in **Table 1e** - Staffing for MCHS and SCHEIS (See Supporting Document 1) are the names and qualifications (briefly described) of senior level management employees who serve in lead MCH-related positions and program staff who contribute to the state's planning, evaluation, and data analysis capabilities. Also included in the summary are the number of parent and family members, including CSHCN and their families, who are on the state Title V program staff and their roles (e.g., paid

consultant or volunteer.) In addition, MCH workforce information such as the tenure of the state MCH workforce is included in the summary.

Maternal and Child Health Services (MCHS) is comprised of three program managers, 16 professionals, and 6 support staff. All staff members are housed in the central office. The Service Director for MCHS position recently became vacated in April 2015 when the previous Service Director, Lorraine Freed Garg, MD, MPH a pediatrician with a subspecialty in Adolescent Medicine, moved out of state.

Reproductive and Perinatal Health Services (RPHS) is staffed by 10 professionals and 3 support personnel and a Program Manager. A new Program Manager was hired in 2016. The program is responsible for the regional MCH Consortia, Certificate of Need rules and MCH Consortia regulations, morbidity and mortality reviews, Title V Liaison with the Healthy Start projects, Family Planning, perinatal addictions and fetal alcohol syndrome prevention projects, postpartum mood disorders initiative, Improving Pregnancy Outcomes Initiative, and preconceptual health. Several professional staff members participate in the various subcommittees of the Home Visiting Work Group. The Healthy Mothers, Healthy Babies Coalitions and Black Infant Mortality Reduction Initiative were rolled into the Improving Pregnancy Outcomes Initiative. Resources for staff have been from federal MCH Block Grant, MIECHV, and the Preventive Health and Health Services Block Grant.

The Child and Adolescent Health Program (CAHP) is staffed by 5.5 professional staff - 3 in Child Health, 2.5 in Adolescent Health, 1 paraprofessional MIS Technician, 1 administrative support staff and the Program Manager. Specifically, Childhood Lead poisoning and Prevention has one Primary and Preventive Health Services Coordinator, 2 professionals and 1 MIS technician. Funding resources include both federal (MCH Block Grant, CDC cooperative agreement for lead poisoning surveillance and primary prevention, DHHS, FYSB, ACF Title V Abstinence Education Program [AEP] and DHHS, FYSB, ACF Personal Responsibility Education Program [PREP]) and state (MCH and Lead childhood lead poisoning) funding. All staff are housed in the Trenton office. The CAHP Manager has oversight responsibilities for childhood lead poisoning and prevention, two teen pregnancy prevention programs and CDCs WSCC model in public schools, grades six and above. Child Health was awarded Superstorm Sandy Recovery funding in the amount of $10.3M for 3 components: 1) Public education and professional development; 2) blood lead screening using the LeadCare II analyzer; limited nursing interventions, and dust and soil sampling of targeted housing; 3) enhancement of HomeTrax (a healthy homes database). The time-only extension that funded Superstorm Sandy Recovery efforts ends June 30, 2016.

Teen pregnancy prevention staff consists of one full-time PREP Coordinator and one part-time AEP Coordinator. The AEP Coordinator position was approved to hire on March 28, 2015. One professional staff person is assigned responsibility for the CDC WSCC project and the position is currently vacant. CAHP staff have varied professional backgrounds including nursing, nutrition, health education, research and data analysis.

Community Health and Wellness Services in the Division of FHS was awarded the CDC 1305 cooperative agreement: State Public Actions to Prevent Chronic Disease …and Promote School Health, for basic and enhanced components.

The Children's Oral Health Program (COHP) is comprised of 1 professional staff who reports to the Medical Director, Division of Family Health Services. Dr. Beverly Kupiec-Sce directs program activities which are implemented through regional based programs strategically located in the north, central and south regions of the State. As COHP Director, Dr. Sce maintains a gubernatorial appointment to the NJ State Board of Dentistry and is one of 19 doctoral prepared nurses nationwide serving on the National Nursing Workgroup on Oral Health a component of the National Inter-professional Initiative on Oral Health. The role of the National Oral Health Nursing Workgroup is to shape nursing's role in advancing a national oral health agenda and serves as an expert advisory committee providing input related to nursing's role in improving oral systemic health outcomes as well as expanding access to and reducing disparities in oral health.

The Maternal and Child Health Epidemiology Program (MCH Epi) provides MCH surveillance and evaluation support to MCHS. The mission of the MCH Epi Program is to promote the health of pregnant women, infants and children through the analysis of trends in maternal and child health data and to facilitate efforts aimed at developing strategies to improve maternal and child health outcomes through the provision of data and completion of applied research projects. The MCH Epi Program promotes the central collection, integration and analysis of MCH data. MCH Epi is comprised of three research professional positions. One professional staff position is supported entirely by resources from the MCH Bureau's State Systems Development Initiative (SSDI) grant. The Pregnancy Risk Assessment Monitoring System (PRAMS) survey is coordinated by the MCH Epi Program. Ingrid Morton is the Program Manager for MCH Epi. One of two research professional positions is currently vacant.

Special Child Health and Early Intervention Systems (SCHEIS)

Special Child Health and Early Intervention Systems (SCHEIS) consist of the following programs and services: Early Identification and Monitoring, Newborn Screening and Genetic Services Program, Family Centered Care Services, and the Early Intervention System.

Dr. Marilyn Gorney-Daley is the Director of SCHEIS. Dr. Gorney-Daley is board certified in General Preventive Medicine and Public Health, with a Master of Public Health in Healthcare Organization and Administration. She has over 15 years of experience with NJDOH and previously served as the Medical Director of SCHEIS. All SCHEIS staff members are housed in the central office.

The Early Identification and Monitoring (EIM) Program is responsible for the reporting and monitoring of children with birth defects, special needs, and pulse oximetry screening fails, Autism, and the Early Hearing Detection and Intervention Program. The EIM Program is comprised of a staff of 8 professionals, 6 support staff, and a Program Manager, Joy Rende who holds a Master of Science in Hospital Administration, a National Certification in Maternal Child, ANCC Certification in Nurse Executive and a Certification Public Health Management. Ms. Rende has 25 years of leadership experience and a Neonatal Intensive Care clinical background. Resources for staff come from the MCH Block Grant, a HRSA grant for universal newborn hearing screening, and 2 CDC cooperative agreements (EHDI and Birth Defects Surveillance), and the Autism Medical Research and Treatment Fund.

The Newborn Screening and Genetic Services Program is responsible for the follow-up of newborns with out-of-range screening results. This program also provides partial support through its grants to specialty care centers and facilities for metabolic and genetic services, pediatric endocrine services, pediatric hematologic services, pediatric pulmonary services and specialized confirmatory and diagnostic laboratory services. The Newborn Screening and Genetic Services Program is currently comprised of a staff of 11 professionals and 3 support staff.

The Family Centered Care Services Program (FCCS) is responsible for funding, monitoring, and evaluating services provided by the 21 Title V funded Case Management Units, Family WRAP family support services, 9 Child Evaluation Centers which include 4 FAS Diagnostic Centers, 5 Cleft Lip/ Cleft Palate centers, 3 Tertiary Care Centers, 2 Organ Donor and Tissue Sharing Donor awareness education programs, and the 7 Ryan White Part D funded Statewide Family Centered HIV Care Network sites. Resources for staff come from the MCH Block Grant and from the HRSA AIDS Bureau under Ryan White Part D. This program is comprised of a staff of 6 professionals, 2 support staff, and a Program Manager, Mrs. Pauline Lisciotto, RN, MSN. The Coordinator of Special Child Health Services, Case Management is Ms. Felicia Walton, BA. Ms. Linda Barron, RN-CPN, MSN, coordinates SPSP, and Mrs. Ellen Dufficy, RN, M.Ed. coordinates Ryan White Part D. The FCCS program welcomed 2 new staffs: Ms. Dawn Mergen, Quality Assurance Specialist, and Mr. Christopher Santin, Health Data Specialist.

The FCCS program welcomed 2 new staffs: Ms. Dawn Mergen, Quality Assurance Specialist, and Mr. Christopher Santin, Health Data Specialist.

The Early Intervention System is headed by Terry Harrison, Part C Coordinator. This System provides services to infants and toddlers with disabilities or developmental delays and their families in accordance with Part C of the Individuals with Disabilities Education Act.

All programs within SCHEIS have staff with varied professional backgrounds including nursing, medicine, physical therapy, epidemiology, speech pathology, public health, research, statistics, family counseling, education, and genetic counseling. Both senior level and support staff include parents of children with special health care needs such as developmental delay, seizure disorder, specific genetic syndromes, and asthma.

To promote and provide culturally competent approaches in its services delivery across programs, NJ actively:
(1) Collects and analyzes data according to different cultural groups (e.g. race, ethnicity, language) and use the data to inform program development and service delivery.
(2) Ensures the provision of training for staff, family leaders, volunteers, contractors and subcontractors in the area of cultural and linguistic competence.
(3) Collaborates with informal community leaders/groups (e.g. natural networks, informal leaders, spiritual leaders, ethnic media and family advocacy groups) and families of culturally diverse groups in needs/assets assessments, program planning, service delivery and evaluation/ monitoring/quality improvement activities.
(4) Secure allocation of resources to adequately meet the unique access, informational and service needs of culturally diverse groups.
(5) Develop and implement performance standards for staff and contractors that incorporate cultural competence practices and policies.
(6) Provide policies and guidelines that support the above identified items and approaches.

A table (Table 1e - Staffing for MCHS and SCHEIS) has been attached (see Supporting Document #1) which summarizes the names and qualifications of senior level management employees who serve in lead MCH-related positions and program staff who contribute to the state's planning, evaluation, and data analysis capabilities.

Title V SCHEIS staff are active participants and represent the NJDOH on the New Jersey Statewide Network on Cultural Competence (NJSNCC) to ensure that there is access to equitable and quality services for individuals, families, and communities through culturally and linguistically appropriate service delivery. As part of their mission, the NJSNCC holds an annual conference for service providers, policymakers, researchers and other stakeholders on culturally competent care. The most recent annual conference held November 9, 2015 focused on Improving Trauma-Informed Care and Services for Diverse Populations: Best and Promising Practices. Some of the workshops included trauma-informed care for victims of Superstorm Sandy, building resiliency in diverse families of children with special healthcare needs impacted by Superstorm Sandy, and working with interpreters and trauma survivors. At one of these presentations, "Building Resiliency in Diverse Families of Children with Special Healthcare Needs Impacted by Superstorm Sandy," a parent provided some insights into how environmental stressors can impact the life of a child with special healthcare needs and how programs can help diverse families address that trauma and enhance resiliency.

Highlights from this conference included:

- Identifying and implementing key strategies for discovering strengths and promoting resilience in practice with immigrants and refugees.
- How Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) are addressing lifespan trauma in culturally diverse and immigrant families in Essex County through promotion and prevention efforts.
- Learning how to find and use resources to support individual and organization self-assessments and development and implementation of action plans designed to help them become more trauma-informed individuals and organizations.

One of the afternoon workshops provided an overview of bullying and documented the lifelong serious and traumatic harm that this common type of physical and emotional behavior produces, entitled: "Bullying and Trauma: Brief Overview of Bullying-Related Harm on Diverse Populations: Evidence and Implications."

Highlights of this presentation included the following:

- The disproportionate use of bullying to target children and youth based on race, ethnicity, disability, and sexual orientation and its impact on children and youth.
- Identifying and understanding the supports and interventions that can help address the trauma caused by bullying.
- Engaging in practices that increase public awareness for violence prevention and restorative practices.

The NJSNCC recently began conducting webinar presentations for services providers and other interested individuals that focus on cultural competence. During the 2015 Spring Webinar Series, presentations on medical homes were continued, but a more global perspective was taken which included all children and youth with special health care needs (CYSHCN). The presentation focused on how a culturally competent medical home can have more impact and positive results in caring for CYSHCN and their families. The presentation aimed to:

- Define and identify methods for building a culturally competent medical home.
- Review strategies to connect CYSHCN with a culturally competent medical home provider.
- Discuss approaches that can be used to engage the practice team and integrate care navigators within clinical practice settings.
- Describe incentives to engage the medical providers to buy into the medical home concept.
- Customize a medical home model that fits your community needs and effective methods to educate families about the medical home.

Additional webinar presentations were conducted in the Spring of 2016.

- "Community Interpreting and the Challenge of Serving Limited English Proficient People"- This webinar discussed the professional activities of translation and interpreting, and the skill and qualifications needed to do each one effectively. The focus was on community interpreting and the different types and skills levels of interpreters employed in this sector. Current national standards for training community interpreters and how these standards can be realistically applied within different programs and systems were also discussed.
- "Racial/Ethnic Minority Fathers of Individuals with Autism: Considerations for Care and Support" - This webinar discussed the presenter's research on what fathers of color report to be helpful support from service providers and schools. It also touched on the psychosocial aspects of autism spectrum disorder on the family system, with a particular focus on fathers, and the rewards and challenges of the fathering experience based on factors that influence racial/ethnic minority fathers of individuals with autism.

FHS recently evaluated its current and future workforce requirements for the State's MCH Services. The evaluation resulted in reclassification of titles to meet the needs of the changing roles and requirements and keeping aligned with the DOH's strategic plan. FHS hired employees and are hiring new employees in the title series of Health Data Specialist and Analyst, Research and Evaluation to support MCH Epidemiology Program and SCHEIS Program. Additionally, we are preparing to hire additional Quality Assurance Specialists. Hiring employees in these titles will improve effectiveness and efficiency of the public health system especially in the MCH programs. The vacant positions were related to retirements, resignations and promotions.

DOH recently planned a Performance Management Training. Two classroom training sessions were held in June, in addition to a webinar that was available to all staff. This training will provide staff to oversee and improve the actions that it takes to enact health policies and plans, to assess health outcomes of at risk maternal and child health communities and to adapt or change policies in order to better achieve the

desired outcomes. The establishment and implementation of a Performance Management System is also a sound operation and management practice and a requirement for successful Public Health Accreditation as the Department seeks to become a nationally accredited health department.

II.B.2.c. Partnerships, Collaboration, and Coordination

This section summarizes the relevant organizational relationships which serve the MCH populations and expand the capacity and reach of the state Title V MCH and CSHCN programs. **Table 1f** - MCH Organizational Relationships with Partnerships, Collaboration, and Cross-Program Coordination (See Supporting Document #1) summarizes the partnerships, collaborations, and cross-program coordination established by the state Title V program with public and private sector entities; federal, state and local government programs; families/consumers; primary care associations; tertiary care facilities; academia; and other primary and public health organizations across the state that address the priority needs of the MCH population but are not funded by the state Title V program.
Sections II.F.2. and II.F.3. describes relevant organizational relationships between FHS and the State Human Services agencies (mental health, social services/child welfare, education, corrections, Medicaid, SCHIP, Social Security Administration, Vocational Rehabilitation, disability determination unit, alcohol and substance abuse, rehabilitation services); the relationship of State and local public health agencies (including MCH Consortia) and federally qualified health centers; primary care associations; tertiary care facilities; and available technical resources which enhance the capacity of the Title V program.

Section II.F.2. also describes the plan for coordination of the Title V program with (1) the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT), (2) other federal grant programs (including WIC, related education programs, and other health, developmental disability, and family planning programs), and (3) providers of services to identify pregnant women and infants who are eligible for Title XIX and to assist them in applying for services.

New Jersey has prided itself on its regional MCH services and programs, which have been provided through the Maternal Child Health Consortia (MCHC), an established regionalized network of maternal and child health providers with emphasis on prevention and community-based activities. The MCHC are charged with developing regional perinatal and pediatric plans, total quality improvement systems, professional and consumer education, transport systems, data analysis, and infant follow-up programs. The three MCHC are located in the northern, central and southern regions of the state, with the northern region representing the largest number of births.

The Federally Qualified Health Centers (FQHCs) operate in all of NJ's 21 countries. The 20 FQHCs have a combined 110 licensed satellite sites throughout the State. As a consequence of expansion and capacity-building initiatives overall growth in the number of uninsured visits reimbursed has been exponential. In SFY 2014, almost 212,000 uninsured residents were serviced and over 522,000 uninsured visits reimbursed. The portion of the annual assessment that is allocated to the FQHCs in SFY 2015 is $31 million. In SFY 2015, the FQHC–Uncompensated Care Fund is funded at $31 million.

The Federally Qualified Health Centers (FQHCs) operate in all of NJ's 21 countries. The 21 FQHCs have a combined 110 licensed satellite sites throughout the State. As a consequence of expansion and capacity-building initiatives overall growth in the number of uninsured visits reimbursed has been exponential. In SFY 2014, almost 212,000 uninsured residents were serviced and over 522,000 uninsured visits reimbursed. In SFY 2015, the FQHC–Uncompensated Care Fund is funded at $31.5 million. In SFY2015, the FQHCs served a total of 160,456 uninsured residents and 406,267 uninsured visits were reimbursed. The decrease in the number of uninsured residents is a result of the Affordable Care Act and Medicaid Expansion.

The NJ Title V CYSHCN Program, also referred to as Special Child Health and Early Intervention Services (SCHEIS), located in the NJDOH, partners, collaborates, and coordinates with many different governmental and nongovernmental entities, on federal, state, and local levels, as well as parents,

families and caregivers, primary care physicians, specialists, other health care providers, hospitals, advocacy organizations, and many others to facilitate access to coordinated, comprehensive, culturally competent care for CYSHCN. The Title V CYSHCN program works with programs within DHS and DCF in addressing many needs facing CYSHCN including medical, dental, developmental, rehabilitative, mental health, and social services. DHS administers Title XIX and Title XX services and provides critical supports for ensuring access to early periodic screening detection and treatment for CYSHCN. The State DHS Medicaid, Children's Health Insurance Program Reauthorization Act (CHIPRA) NJ FamilyCare Program, and the Division of Disability Services afford eligible children comprehensive health insurance coverage to access primary, specialty, and home health care that CYSHCN and their families need.

In order to ensure access to health insurance and benefits to enrolled CYSHCN, SCHEIS collaborates with the Department of Banking and Insurance (DOBI), Division of Insurance colleagues in the development of policy and procedure; i.e., Grace's Law, EIS, and Autism. Likewise, DOBI partners participate with SCHEIS in provider and consumer education and advocacy and regularly provide technical assistance and training at the SCHS quarterly meetings. State SCHEIS staffs are dialoguing with DOBI staff in planning for NJ implementation of the Patient Protection and Affordable Care Act (PPACA).

The DCF is focused on strengthening families and achieving safety, well-being, and permanency for all NJ's children. Current priorities focus on child welfare, safety, health, family strengthening, and the establishment of foster homes. DCF is also engaged in reengineering child abuse prevention, building capacity in the child behavioral health system, and improving the system of health care for children in the State's care. Collaboration between State SCHEIS, local agencies implementing CYSHCN health and related support services, and the statewide DCF system are ongoing to ensure access to health and related services to the most vulnerable CYSHCN.

The Statewide Parent Advocacy Network (SPAN) and the NJ-AAP are key partners with the Title V Program in NJ in many initiatives and projects to better serve CYSHCN and empower families. The Statewide Community of Care Consortium, a leadership group of SPAN, dedicated to improving New Jersey's performance on the six core outcomes for CYSHCN and their families, includes three co-conveners from Title V, SPAN and AAP. This group also includes DHS, DCF, the NJ Primary Care Association, and over 60 statewide participating stakeholder organizations. The Community of Care Consortium partners are continuing to work to improve the access of children with mental health challenges to needed care, and to improve the capacity of primary care providers to address mental health issues within their practice. A Family Guide to Integrating Mental Health and Pediatric Primary Care (NAMI) has been developed and shared with families. Community of Care co-conveners continue to meet with New Jersey's child protection agency, DCF Division of Protection and Child Permanency, about addressing challenges for children with mental health needs under their care.

Section II.F.3. Family/Consumer Partnerships provides more detail on the relevant organizational relationships which serve the MCH populations and expand the capacity and reach of the state Title V MCH and CSHCN programs.

II.C. State Selected Priorities

The State Priority Needs selected by New Jersey for its Title V program during the 5-year reporting period have been determined by a thorough examination of the findings from the state's 5-Year Needs Assessment, as highlighted in the Needs Assessment Summary of the first-year Application/Annual

Report. This section describes the relationship of the State Priority Needs, the National and State Performance Measures, and the capacity and resources of the State Title V program.

Table 10 - State Priority Needs from Five-Year Needs Assessment Form 9

State Priority Needs (SPNs)	New (N), Replaced (R) or Continued (C) Priority Need for this 5-Year Reporting Period			Rationale including National and State Performance and National Outcome Measure
	N	R	C	
1) Increasing Healthy Births			X	NPM 1,2,3; NOMs 1,2,3,5,6,7,8,21,22; SPM 1
2) Improving Nutrition & Physical Activity			X	NPM 8; NOM 9,11,13
3) Reducing Black Infant Mortality			X	NPM 1,2,3,4,5; SPM 1; NOM 1-9
4) Promoting Youth Development			X	NPM 6,10,11,12; NOM 10,11,13,15,16,17
5) Improving Access to Quality Care for CYSHCN			X	NPM 11,12; SPM 3,4,5; NOM 18,19,20,23
6) Reducing Teen Pregnancy			X	NPM 11
7) Improving & Integrating Information Systems			X	All NPMs, SPMs, NOMs
8) Smoking Prevention	X			NPM 14

SPN #1. Increasing Healthy Births is a long standing State Priority Need (SPN) that encompasses reducing low birth weight, preterm births, infant mortality, and increasing first trimester prenatal care adequate prenatal care, and Maternal/Women's Health. SPN #1 addresses the needs of the population domains of Maternal/Women's Health and Perinatal/Infant Health and is impacted by the NPMs 1, 2 and 3. Several initiatives address healthy births including the Home Visiting Program, Healthy Start outreach activities, Community Action Team projects based on FIMR findings, the Perinatal Addictions Prevention Projects and most recently the Improving Pregnancy Outcome Initiative.

Demonstrating its prioritization of Increasing Health Births, RPHS released in 2014 a competitive request for applications to improve perinatal outcomes, called the Improving Pregnancy Outcomes (IPO) Initiative that requires incorporation of the Life Course Theory and uses the services models of Community Health Workers and Central Intake. The IPO Initiative is coordinated with existing federal and state-funded initiatives including but not limited to Healthy Start, MIECHV, Strong Start, Title X Family Planning, Childhood Lead Poisoning Prevention, Healthy Homes, Perinatal Addictions Prevention, Postpartum Mood Disorders, Coordinated School Health, WIC, Federally Qualified Health Centers (FQHCs), and the activities of the Community Health & Wellness Service Unit of the FHS (smoking, diabetes, cardiac, cancer, obesity prevention, physical fitness, hypertension).

SPN #2. Improving Nutrition and Physical Activity is a relatively recent SPN to address the obesity epidemic. The SPN #2 addresses needs in the 4 population domains of Maternal/Women's Health, Perinatal/Infant Health, Child Health, and Adolescent/Young Adult Health and impacts on NPM #8 and NOMs 9 and 11. NJ had one of the highest obesity rates among low-income children 2 to 5 years of age at nearly 18 percent in 2008. The obesity epidemic is taking a toll on the future health of our children by contributing to the rise in related chronic diseases and disabilities, and adding billions of additional dollars in health care costs. Children who are obese are at grave risk of lifelong, chronic health problems like heart disease, asthma, arthritis and cancer.

In SFY2014, DOH Adolescent Health staff, in collaboration with Coordinated School Health (CSH) regional grantees and advisory experts from several State departments and state-level professional organizations created three evidence-based or best practice actions each in the physical education and activity and the nutrition services components of the Coordinated School Health / Whole School, Whole Community, Whole Child (CSH/WSCC model). The physical education actions were developed in collaboration with NJ Association of Health, Physical Education, Recreation and Dance (NJ AHPERD)

and the nutrition services actions were developed with guidance from the NJ Department of Agriculture and the USDA Regional Office

SPN #3. Reducing Black Infant Mortality has been a long standing priority for MCHS with special emphasis in 1985 when the Infant Mortality Reduction Initiative was initiated. SPN #3 addresses the needs of the population domains of Maternal/Women's Health and Perinatal/Infant Health and is impacted by the NPMs 1, 2, 3, 4, and 5.

In 2013 NJDOH was invited to participate in the third round of the National Governors Association Learning Network on Improving Birth Outcomes Initiative (NGA IBO Initiative). NJDOH created three working groups to develop key recommendations regarding the improvement of birth outcomes. In 2014 NJDOH was also invited to participate in the Infant Mortality Collaborative Improvement and Innovation Networks (IM CoIIN) sponsored by the MCH Bureau with technical assistance from National Institute for Children's Health Quality. IM CoIIN is a state-driven HRSA-coordinated partnership to accelerate improvements in infant mortality by helping states: 1) innovate and improve their approaches to reducing infant mortality and improving birth outcomes through communication and sharing across state lines; and 2) use the science of quality improvement and collaborative learning to improve birth outcomes. The multi-sector IM CoIIN State Team from NJ identified two priority areas - improving postpartum rates and smoking cessation. The NGA IBO Initiative workgroups will continue as the IM CoIIN Strategy Teams to develop recommendations for improving birth outcomes and preventing infant mortality.

In 2014 RPHS implemented the IPO Initiative as a means to prevent infant mortality in the highest risk communities. The IPO Initiative through a collaborative coordinated community-driven approach will work to improve maternal and infant health outcomes for high-need women of childbearing age and their families, while reducing racial, ethnic and economic disparities in those outcomes. The IPO Initiative with a Central Intake model and Community Health Workers will be collaborating with the IM CoIIN to implement the recommendations.

SPN #4. Promoting Youth Development addresses the broad needs of the population domain Adolescents and Young Adults. Prior emphasis had been placed on reducing risk-taking behaviors. A more strength-based approach is being emphasized by promoting youth development that will have a positive effect on Life Course and multiple health and wellness outcomes. SPN #4 includes NPMs 7, 8,10, 11 and 12, and NOMs 9, 11, 15, 16 and 17.

Within MCHS, youth development and teen pregnancy are being addressed by the Personal Responsibility and Education Program (PREP) and ACF's Title V Abstinence Education Program (AEP). Through the Coordinated School Health/ Whole School, Whole Community, Whole Child (CSH/WSCC) project, 22 of 28 (78%) school partners completed a school climate and culture survey and received technical assistance on interpreting the results and potential next step actions to address harassment, bullying and other aggressive or violent behavior. Physical inactivity is addressed by the ShapingNJ Partnership, in the school setting as well as in the community.

SPN #5. Improving Access to Quality Care for CYSHCN is prioritized through collaboration and partnership building, targeting resources and efforts to maintain capacity, and comprehensively addressing the six MCHB core outcomes for CYSHCN and State Performance Measures (#3, 4, & 5, and impacts National Performance Measures 11 and 12.

The network of specialty providers, linkages with enabling services provided by Special Child Health Services Case Management Units (CMUs), collaboration with intergovernmental agencies and community-based organizations (refer to stakeholder list), and leadership from the State agency strengthens the safety net of access to care for NJ's CYSHCN. Although many of NJ's CYSHCN have access to primary care, the coordination of care for medically fragile children is often managed through their specialty providers; Child Evaluation Centers (CECs), Fetal Alcohol Syndrome/and Alcohol Related Neurodevelopmental Disorder (FAS/ARND) Centers, Cleft Lip/Palate Craniofacial Anomalies Centers, Tertiary Care Centers and Ryan White Part D HIV Care Network., and NJ is attempting to reverse that

trend. SCHEIS is working with the American Academy of Pediatrics New Jersey Chapter Pediatrics' Pediatric Council on Research and Education's (PCORE) and the Statewide Parent Advocacy Network's (SPAN's) efforts to promote medical home initiatives developed to promote collaboration between pediatric subspecialists and primary care providers. NJ is working toward all CYSHCN receiving high-quality, comprehensive care through a medical home that assures timely access to necessary pediatric specialty and subspecialty care, community supports, and transition to adult care when appropriate. In 2015, the FCCS program received a HRSA Integration Systems Grant (ISG) to address the overarching goal of increasing medical home for CYSHCN by 20%. Partners of this project include SPAN, NJ-AAP, and SCHS CMUs.

Title V efforts to improve quality of care included continued collaboration with many partners in addressing the 6 core outcomes for CYSHCN through parent-professional medical home initiatives. Using a multi-county approach, outreach was conducted to pediatric and family practices and FQHCs throughout the southern and central regions of NJ. The SCHS CMUs provided lists of providers that routinely served CYSCHN in their caseloads, and SPAN and PCORE invited practices to "Kick Off" events providing an overview of the medical home/ISG initiative. Title V provided consultation on specialized pediatric services and case management, presented at medical home learning collaborative meetings and care coordination webinars, and provided resources to practices.

NJ continues to collaborate with Consortium of Care partners to address the 6 core outcomes through Consortium of Care activities and improve quality of care such as medical home training and consultation with providers. Participants share updates in programs and services to facilitate appropriate referrals resulting in access to care, including Perform Care, services for CYSHCN with developmental disabilities through DCF, and the DHS Division of Developmental Disabilities. Likewise, State staffs will continue to provide technical assistance and monitoring of Title V service providers including interviews of clients that have received services. The electronic BDARS and CMRS provides opportunities to view client referrals and service outcomes, and reinforce the SCHS CM-client interactions.

NJ continues to work toward ensuring that a sufficient number of pediatric subspecialists are available statewide to provide high-quality tertiary care to CYSHCN and endorses the interdisciplinary team approach to comprehensive care. In addition to autism care being provided by the CECs, 6 Clinical Autism Centers were funded by the Governor's Council for Medical Research and Treatment of Autism/DHSS to enhance their autism diagnostic and treatment services.

State FCCS staffs and health services grantees attend trainings on health care reform, NJ FamilyCare and Medicaid expansion, participate in CMS webinars, and collaborate with community-based enrollment agencies. They also educate clients and their families about the benefits of health care reform for CYSHCN and their families, and link them to enrollment counselors as appropriate. Anecdotally, the information gained through trainings was particularly of interest for uninsured parents and extended adult family members of CYSHCN.

SPN #6. Reducing Teen Pregnancy has been identified as a priority by several Departments including: DOH, DOE, DHS and DCF with several inter-agency initiatives developed to address this priority. Teenage childbearing can have long-term negative effects on both the teenage mother and the infant. Infants born to teen mothers are at higher risk of being low birthweight and preterm. They are also far more likely to be born into families with limited educational and economic resources. Although teen pregnancy and birth rates are at historic lows, there were 4,188 teen births in NJ in 2013 and the teen birth rate was 14.8 births for every 1,000 adolescent females aged 15-19 years.

Preventing teen births in NJ translates to significant savings for NJ taxpayers. The teen birth rate in NJ declined 51% between 1991 and 2010, saving taxpayers an estimated $339 million in 2010. The total costs of teen childbearing include those sometimes incurred by the children of teen mothers (public health care insurance programs, primarily Medicaid and CHIP, increased child welfare participation, and increased risk for incarceration among adolescents or young adults) and the associated lost tax revenue due to decreased earnings and spending.

PREP funds were awarded to 6 grantees serving at least 50% youth in the 30 high-risk New Jersey municipalities. In SFY 2014, NJ PREP was successfully implemented by six sub-grantees at more than 60 locations in 24 municipalities and 12 counties throughout NJ reaching approximately 2,300 unduplicated youth participants.

Grant funds for Title V AEP was awarded to 4 grantees, 2 in the northern region, one in central and the fourth in the southern region. Abstinence-focused curriculum taught in after-school programs provides adult supervision as well as peer support.

SPN #7. Improving and Integrating Information Systems involves multiple efforts by the MCH Epidemiology Program, FHS and the NJDOH to improve and integrate public health information systems in order to promote public health surveillance and to improve the delivery of public health services and programs. Activities are related to almost every NPMs, SPMs and NOMs. Improving and Integrating Information Systems is a significant priority for the MIEC Home Visiting Program and the IPO Initiative. Improving the MCH system of care will depend on quality data from an integrated information system. Examples of improving access to and integration of public health information are discussed in sections specific to the performance measures and health systems capacity indicators.

The Electronic Birth Certificate (EBC) System is in the process of being upgraded to a web-based Electronic Birth Registry System (EBRS). The Bureau of Vital Statistics and Registration has involved staff from FHS and the MCH Consortia in the development of the EBC upgrade. In addition to improving the timeliness, quality, and security of NJ's birth data, the adoption of a web-based EBRS would also facilitate real-time linkages to other data sets, thus laying the groundwork for the development of an electronic child health registry or integrated MCH information system.

SP #8. Smoking Prevention

Smoking prevention has been a long-term NJDOH priority. The Five-Year Needs Assessment identified smoking prevention as a SPN from past MCH Block Grant Applications, the annual NJDOH Budget Planning process, and monitoring Healthy People 2020 objectives. Recent involvement of FHS in the NGA Improving Birth Outcomes Initiative and the IM CoIIN has increased the recognition that smoking prevention plays in improving birth outcomes, preventing prematurity and reducing infant mortality. FHS has several programs that include a smoking prevention component that could be strengthened with further collaboration with the Community Health and Wellness Service Unit.

II.D. Linkage of State Selected Priority Needs with National Performance and Outcome Measures

NJ has selected the following National Performance Measures (NPMs) based on the State Priority Needs and the findings of the Five-Year Needs Assessment. The selected NPM will be addressed over the next five-year period of the Title V program. Over the next year Evidence-Based / Informed Strategy Measures (ESMs) will be finalized which directly impact the selected NPMs and in turn drive the improvement of NOMs.

Performance Measures Framework from Appendix E

NPM #	National Performance Measure (NPM) Priority Areas	MCH Population Domains	Rationale: NOMs
1	Well woman care	Women/Maternal Health	1, 2, 3, 5, 6, 7, 8, 9, 10, 11
4	Breastfeeding	Perinatal/Infant Health	1, 3, 4, 5, 6, 8, 9, 10, 20, 22
5	Safe sleep	Perinatal/Infant Health	8, 9, 9.5, 15
6	Developmental Screening	Child Health	13, 17, 18, 19
8	Physical Activity	Child and Adolescent Health	19, 20
10	Adolescent Well Visits	Adolescent Health	13, 16, 17, 18, 19, 20, 21, 22
11	Medical home	Children and CSHCN	13, 15, 16, 17, 18, 19, 20, 21, 22
12	Transitioning to Adulthood	Children and CSHCN	17, 18, 19, 20, 21, 22
13	Oral health	Cross Cutting/Life course	14, 19
14	Smoking	Cross Cutting/Life course	Most

NPM 1-Percent of women with a past year preventive medical visit

	2016	2017	2018	2019	2020
Annual Objective	73	74	74	75	75

NPM 4-A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months

	2016	2017	2018	2019	2020
Annual Objective	81	2	82	83	83
Annual Objective	21	21	22	22	23

NPM 5-Percent of infants placed to sleep on their backs

	2016	2017	2018	2019	2020
Annual Objective	69	70	70	71	71

NPM 8-Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

	2016	2017	2018	2019	2020
Annual Objective	32	32	33	33	34

NPM 11-Percent of children with and without special health care needs having a medical home

	2016	2017	2018	2019	2020
Annual Objective	39	39	40	40	41

NPM 12-Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

	2016	2017	2018	2019	2020
Annual Objective	43	43	44	44	45

NPM 13-A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

	2016	2017	2018	2019	2020
Annual Objective	46	47	48	49	50

	2016	2017	2018	2019	2020
Annual Objective	80	81	82	82	83

NPM 14-A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

	2016	2017	2018	2019	2020
Annual Objective	15	15	15	15	15
Annual Objective	20	19	19	18	18

II.E. Linkage of State Selected Priorities with State Performance and Outcome Measures

NJ has selected the following 5 State Performance Measures (SPMs) to address the unique MCH needs of the State. Selection of the SPMs is based on the findings of the Five-Year Needs Assessment, past MCH Block Grant Annual Applications/Reports, the monitoring Healthy People 2020 objectives process, and the annual NJDOH Budget Planning process.

New Jersey Selected State Performance Measures:

#	Selected State performance Measure (SPM)	Domain	Related NOM
1	Black Preterm Births	Perinatal/Infant Health	1 to 11
2	Elevated Lead Screening	Child Health	4, 5, 13, 19
3	Hearing Screening Follow-up	CSHCN	13, 19
4	Referral from BDARS to Case Management	CSHCN	13, 17, 18, 20, 21, 22
5	Age Reporting Autism to BDARS	CSHCN	13, 17, 18, 21

II.F. State Action Plan and Strategies by MCH Population Domain

II.F.1. Introduction

The NJ Five-Year State Action Plan was developed from the Five-Year Needs Assessment. This Action Plan serves as the Application/Annual Report narrative discussion for NJ on the planned activities for the Application year and the activities that were implemented in the Annual Report year. Activities will be discussed in terms of the state's targeted performance and its achievements around the NOMs, NPMs, ESMs and SPMs. The State Action Plan includes a discussion of the health status/outcome and performance measures for each of the six population health domains. The Five-Year Action Plan is also represented in the attached Supporting Document #1 – Table 1a NJ Five-Year Needs Assessment Framework Logic Model.

The Five-Year Action Plan is a tabular representation of the narrative for the Five-Year Action Plan, organized by the six population health domains and each selected NPM. For each selected NPM the related ESMs, NPMs, and NOMs represent the integrated three-tiered performance measurement system from the Logic Model.

This Table should be considered a planning tool to be used in the development of the Five-Year Action Plan that aligns the identified priority needs with the program strategies and performance measures. It is recognized that the Five-Year Action Plan Table submitted in the first Application/Annual Report year (FY16/FY14) will be considered as an interim plan, which will be further refined and completed in the second Application/Annual Report year (FY17/FY15) .

Table 1 - New Jersey Five-Year Needs Assessment Framework Logic Model – Listed by NPM

Domains *(set by HRSA)*	***State Priority Needs*** *based on Needs Assessment*	***Strategies*** *(develop into Evidence-Based Informed Strategic Measures (ESM) for 2017)*	***National Outcome Measures (NOMs)*** *(states select from list)*	***National Performance Measures (NPMs) &*** *State Performance Measures (SPMs)*
1) Women's/ Maternal Health	#1 Increasing Healthy Births	Improving Pregnancy Outcomes (IPO) Initiative; Central Intake (CI) & Community Health Workers (CHW) IM CoIIN; MIEC Home Visiting Program (MIECHV); Office of Women's Health; Perinatal Designation Level regulations, Development of the NJ VON Collaborative, MCH Consortia TQI Activities	1 Infant Mortality; 2 Preterm-related death; 3 Neonatal Mortality; 5, 6, 7, 8, 21 Postpartum hospitalizations with severe morbidity; 22 Maternal Death	**NPM #1 Well Women Care**
2) Perinatal/ Infant Health	#3 Reducing Black Infant Mortality	Improving Pregnancy Outcomes (IPO) Initiative; IM CoIIN; MIEC Home Visiting Program; NJ SIDS Center activities; Healthy Start; HBWW, SUID-CR; Surveillance (PRAMS, EBC)	1, 2, 3, 4 Post-Neonatal Mortality; 5 Perinatal Mortality; 6 Sleep-related SUID death; 7 LBW & VLBW; 8 Preterm Birth; 9	**NPM #5 Infant Safe Sleep** SPM #1 Black preterm births
2) Perinatal/ Infant Health	#3 Reducing Black Infant Mortality	Improving Pregnancy Outcomes (IPO) Initiative; IM CoIIN; MIEC Home Visiting Program; Healthy Start; HBWW, Loving Support© Through Peer Counseling Breastfeeding Program Baby Friendly Hospitals, BF Surveillance (PRAMS, EBC) Breastfeeding and NJ Maternity Hospitals: A Comparative Report	1, 2, 3, 4 Post-Neonatal Mortality; 5 Perinatal Mortality; 6 Sleep-related SUID death; 7 LBW & VLBW; 8 Preterm Birth , 9	**NPM #4 Breastfeeding** SPM #1 Black preterm births
3) Child Health	#2 Improving Nutrition & Physical Activity	ShapingNJ Whole School, Whole Community, Whole Child (WSCC, CDC) School Health	11 Overweight rate; 9 Kids in very good health; 13 Kids without insurance;	**NPM #8 Physical activity** SPM #2 Elevated blood lead screenings
4) Adolescent/ Young Adult Health and 5) CYSHCN	#4 Promoting Youth Development, #6 Reducing Teen Pregnancy	Transition to adulthood needs assessment; SPAN/ISG 1; ARC of NJ	10, 11, 13, 15 Adolescent death 10-19; 16 MVA fatality 15-19 17 Suicide 15-19	**NPM #11 Medical home,**

Domains *(set by HRSA)*	***State Priority Needs*** *based on Needs Assessment*	***Strategies*** *(states identify)*	***National Outcome Measures (NOMs)*** *(states select from list)*	***National Performance Measures (NPMs) &*** *State Performance Measures (SPMs)*
5) CYSHCN and 4) Adolescent/ Young Adult Health	#5 Improving Access to Quality Care for CYSHCN	Case Management Services; NJ AAP/PCORE Medical Home Project; Outreach to providers; Hospital level reports; Audits; Provider education CM level reports; Medicaid Managed Care Alliances, Subsidized Direct Specialty and Subspecialty Services, Participation in Medical Assistance Advisory Council, Arc of NJ	18 CSHNC receiving care in a well-functioning system; 19 % CSHCN & ASD; 20 Kids with a mental/behavioral condition who receive treatment, 23 Timely NBS+ follow-up	**NPM #12 Transitioning to Adulthood** SPM #3 Hearing screening F/U; SPM #4 Referred from BDARS to Case Management Unit; SPM #5 Age reporting autism to BDARS;
6) Life Course		Project REACH, Project PEDS ShapingNJ; MIEC Home Visiting; Dial a Smile Dental Clinic Directory; Miles of Smiles; WIC Newsletter; Special Needs Newsletter;	14 Kids 1-6 with cavities; 9 Kids in very good health;	**NPM #13 Oral health**
6) Life Course	#7 Improving & Integrating Information Systems	IPO, Central Intake / PRA MIEC Home Visiting SSDI, ECCS; VIP; Master Client Index Project	ALL	ALL NPMs
6) Life Course	#8 Smoking Prevention	SSDI, ECCS Mom's Quit Connection; Perinatal Addiction Prevention Project; IPO, Central Intake / PRA MIEC Home Visiting	ALL	**#14 Household Smoking**

II.F.1.a. Women/Maternal Health

Improving the domain of Women's/Maternal Health is crucial to the State Priority Need of Increasing Healthy Births (SPN #1) and the National Outcomes Measures (NOMs) related to decreasing infant mortality. The selection of NPM #1 (Well Women Visits) during the Five-Year Needs Assessment process recognizes the impact the life course approach will have on Increasing Health Births and improving women's health across the life span. The life course approach to conceptualizing health care needs and services evolved from research documenting the important role early life events play in shaping an individual's health trajectory. The interplay of risk and protective factors, such as socioeconomic status, toxic environmental exposures, health behaviors, stress, and nutrition, influence health throughout one's lifetime. NJ has had a long-standing emphasis on improving Women's Health and has promoted several evidence-based strategies to increase preventive medical visits (NPM #1) including: the Improving Pregnancy Outcome Initiative, IM CoIIN, MIEC Home Visiting, Fetal Infant Mortality Review, and Maternal Mortality Review.

Plan for the Application Year - NPM #1

	2009	2010	2011	2012	2013
Percent of women with a past year preventive medical visit	72.86	74.58	72.11	72.93	72.47

Data Source: Behavioral Risk Factor Surveillance System (BRFSS).

Plans for the coming year to promote NPM 1 (Well Women Care) will include the recommendations of the IM CoIIN regarding postpartum visits. The IPO Initiative with Central Intake and Community Health Workers will promote the outreach and referral of women for preventive medical visits through standardized Community Health Screenings and referrals to medical care providers. The MIEC Home Visiting Programs and Healthy Start Programs will continue to case manage mothers and assure preventive medical visits through the monitoring of benchmarks which include a reproductive life plan, medical home and well women visits for Health Start participants and prenatal care, postpartum visits and maternal health insurance for Home Visiting.

In 2014, New Jersey joined a national effort to reduce infant mortality called Collaborative Improvement and Innovation Network (IM CoIIN). IM CoIIN is led by the National Institute of Children's Health Quality (NICHQ) but funded to the Maternal Child Health Bureau (MCHB). "IM CoIIN is a multiyear national initiative to employ quality improvement innovation and collaborative learning". In addition, CoIIN provides a data infrastructure and expert technical assistance to participating states. "The goal of IM CoIIN is to engage federal, state, public and private agency representatives and the community from across the U.S. to coordinate, collaborate and innovate".

New Jersey IM CoIIN has established a multisector State Team collaboration with subject matter experts to address two infant mortality strategic priorities. As part of the CoIIN, New Jersey selected Smoking Cessation and Preconception/Interconception health with a focus on the postpartum visit as strategic priorities to address infant mortality. The utilization of timely data and rapid-cycle quality improvement activities will inform the next steps New Jersey will take to reduce infant mortality.
New Jersey IM CoIIN Smoking Cessation and Preconception/ Interconception Learning Session I Networks convened in March, 2015. Since the launch of the learning networks, New Jersey has conducted multiple rapid-cycle quality improvement activities through statewide collaboration and technical assistance from NICHQ. In July, 2015, several members from the New Jersey's CoIIN State Team will attend the launch of CoIIN Learning Network Session II in Boston, Massachusetts.

Annual Report - NPM #1 (Percent of women with a past year preventive medical visit)

The Improving Pregnancy Outcomes (IPO) Initiative through the use of Community Health Workers and Central Intake is focused on improving maternal and infant health outcomes including women's health with preventive medical visits, preconception care, prenatal care, interconception care, preterm birth, low birth weight, and infant mortality. The IPO Initiative is coordinated with existing federal and state-funded

initiatives including Healthy Start, Maternal Infant and Early Childhood Home Visitation, Strong Start, Title X Family Planning, Childhood Lead Poisoning Prevention, Healthy Homes, Perinatal Addictions Prevention, Postpartum Mood Disorders, Coordinated School Health, WIC, Federally Qualified Health Centers (FQHCs), and the activities of the Community Health and Wellness Services of the FHS (smoking, diabetes, cardiac, cancer, obesity prevention, physical fitness, hypertension).

Through use of Community Health Workers and Central Intake the IPO Initiative targeted limited public health resources to populations and communities with the highest need where impact will be greatest to improve population health outcomes and reduce health disparities. The IPO Initiative is working to improve women's health by completing standardized Community Health Screenings for participating women including the assessment of health insurance, existing medical conditions, mental health needs, and social service needs. The IPO Initiative through case management will assure that appropriate referrals are made and tracked including medical care referrals to promote NPM #1 (Well Women Visits).

NJDOH is participating in the Infant Mortality Collaborative Improvement and Innovation Networks (IM CoIIN) sponsored by the MCH Bureau with technical assistance from National Institute for Children's Health Quality. The IM CoIIN State Team from NJ identified two priority areas - improving maternal postpartum visit rates and smoking cessation. The IPO Initiative will coordinate and collaborate with a variety of community partners to implement the IM CoIIN recommendations from these two focus areas.

Included in improving NPM #1 is a focus on preconception care and early prenatal care. Improving access to prenatal care is essential to promoting the health of NJ mothers, infants, and families. Early and adequate prenatal care is an important component for a healthy pregnancy and birth outcome because it offers the best opportunity for risk assessment, health education, and the management of pregnancy-related complications and conditions. Prenatal care is also an opportunity to establish contacts with the health care system and to provide general preventive visits.

Efforts to improve access to early prenatal care must address the factors related to unintended pregnancy and lack of early pregnancy awareness by focusing on women before they become pregnant. Preconception care is a critical component of prenatal care and health care for all women of reproductive age. The main goal of preconception care is to provide health promotion, screening and interventions for women of reproductive age to reduce risk factors that might affect future pregnancies. Given the relationship between pregnancy intention and early initiation of prenatal care, assisting women in having a healthy and planned pregnancy can reduce the incidence of late prenatal care to promote NPM #1 (Well Women Visits).

The regional quality improvement activities within each of the three Maternal Child Health Consortia (MCHCs) coordinated by RPHS include the regular monitoring of indicators of perinatal and pediatric statistics, fetal-infant mortality review, maternal mortality review, and maternity services reporting through the electronic birth certificate (EBC). Regional quality improvement activities include regular monitoring of indicators of perinatal and pediatric statistics and pathology, including 1) transports with death; 2) non-compliance with rules regarding birth weight and gestational age; 3) cases in which no prenatal care was received; 4) all maternal deaths; 5) all fetal deaths over 2,500 grams not diagnosed as having known lethal anomalies; 6) selected pediatric deaths and/or adverse outcomes; 7) immunizations of children 2 years of age; and 8) admissions for ambulatory care sensitive diagnoses in children.

Quality improvement is accomplished through Fetal-Infant Mortality Review and Maternal Mortality Review systems, as well as analyzing data collected through the EBC. Currently, all hospitals providing maternity services report births through the EBC. The TQI Committee reviews the data and makes recommendations to address either provider specific issues or broad system issues that address multiple providers or consumer groups within each Consortium region.

II.F.1.b. Perinatal/Infant Health

The domain of Perinatal/Infant Health determines the health of a child throughout the Life Course. NJDOH has identified the State Priority Need (SPN) of Reducing Black Infant Mortality and selected the related NPMs 4 (Breastfeeding) and 5 (Infant Safe Sleep) as a result of the Five-Year Needs Assessment process. NJ has implemented several evidence-based strategies related to NPM 4 & 5 which in turn will impact on several NOMs (1, 2, 3, 4, 5, 6, 8, 9, 9.5). Evidence-based strategies related to NPM 4 & 5 are listed in the Logic Model.

Plan for the Application Year - NPM 4:
A) Percent of infants who are ever breastfed and
B) Percent of infants breastfed exclusively through 6 months

Promoting breastfeeding has been a long-standing priority for FHS. Breastfeeding is universally accepted as the optimal way to nourish and nurture infants, and it is recommended that infants be exclusively breastfed for the first six months. Breastfeeding is a cost-effective preventive intervention with far-reaching benefits for mothers and babies and significant cost savings for health providers and employers. Breastfeeding provides superior nutrition, prevents disease and enhances infant development. FHS has developed many strong partnerships to strengthen breastfeeding-related hospital regulations, promoting breastfeeding education, training and community support.

The Healthy People 2020 breastfeeding objectives are for 81.9% of mothers to initiate breastfeeding, for 60.6% of new mothers to continue breastfeeding until their infants are six months old, for 34.1% to breastfeed until one year, for 46.2% to exclusively breastfeed through three months, and for 25.5% to breastfeed exclusively through six months. In the 2014 Breastfeeding Report Card (2011 births) from the CDC, 81.6% of NJ newborns were ever breastfed (NPM #4A); 56.2.9% breastfed at six months; 30.9% breastfed at twelve months; 39.6% exclusively breastfed at three months; and 22.3% exclusively breastfed at six months (NPM #4B). These rates are all above the rates of the previous year and continue the upward trend compared to the 2010 report (2007 births), when hospitals began making progress in implementing the World Health Organization's Ten Steps to Successful Breastfeeding.

Table NPM #4

	2007	2008	2009	2010	2011
Percent of infants who ever breastfed	72.1	75.8	80.5	77.1	81.6
Percent of infants breastfed exclusively through 6 months	10.0	11.8	14.0	13.0	22.3

Notes - Source – the CDC's National Immunization Survey.
http://www.cdc.gov/breastfeeding/data/NIS_data/
http://www.cdc.gov/breastfeeding/pdf/2014breastfeedingreportcard.pdf

Efforts to promote BFHI designation through training, technical assistance, and mini-grants will continue to promote NPM 4A & B. Surveillance through the Breastfeeding Report Card and the mPINC survey will continue to identify areas of potential improvement.

Many hospitals employ International Board Certified Lactation Consultants who provide early support and information to breastfeeding mothers. WIC will continue to provide breastfeeding promotion and support services to pregnant and breastfeeding women who participate in the Program. The CDC State Public Health Actions Grant will continue with webinars and technical assistance calls to the 18 participating hospitals.

Existing FHS programs that promote breastfeeding and include performance measures for increasing breastfeeding include the IPO Initiative and the MIEC Home Visiting Program which now serve all 21 counties and targets high-need communities. A Breastfeeding indicator, increase over time in the proportion of mothers who breastfeed their 6-week-old infants, is included in the MIECHV and Healthy Start performance benchmarks.

Plan for the Application Year - NPM 5: (Percent of infants placed to sleep on their backs)

Promoting infant safe sleep was selected as NPM #5 during the Five-Year Needs Assessment process for its importance in reducing preventable infant deaths and its potential impact on improving NOMs 1, 2, 3, 4, 5, and 6. Sleep-related infant deaths, also called Sudden Unexpected Infant Deaths (SUID), are the leading cause of infant death after the first month of life and the third leading cause of infant death overall. Sleep-related SUIDs include Sudden Infant Death Syndrome (SIDS), accidental suffocation and strangulation in bed and unknown causes. Due to the heightened risk of SIDS when infants are placed to sleep in side or stomach sleep positions, health experts and the American Academy of Pediatrics (AAP) have long recommended the back sleep position. In 2011, AAP expanded its recommendations to help reduce the risk of all sleep-related deaths through a safe sleep environment that includes use of the back-sleep position, on a separate firm sleep surface (room-sharing without bed sharing), and without loose bedding. Additional higher-level recommendations include breastfeeding and avoiding smoke exposure during pregnancy and after birth. These expanded recommendations have formed the basis of the National Institute of Child Health and Development (NICHD) Safe to Sleep Campaign.

Table NPM #5

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Percent of infants placed to sleep on their backs	57.8	60.6	61.1	64.2	61.8	65.6	65.7	67.4	68.9	70.1

Notes - Source – NJ PRAMS.
http://www.cdc.gov/prams/pramstat/index.html

Plans for the coming year to promote safe infant sleep include continued safe sleep education through the SIDS Center of NJ (SCNJ), MIEC Home Visiting Program and prevention activities of the Sudden Unexpected Infant Death Case Review (SUID-CR) grant. The SUID-CR Coordinator will be participating in the Infant Mortality CoIIN sessions that focus on improving infant safe sleep practices. Evidence-based strategies proposed by the IM CoIIN sessions on infant safe sleep will be considered by the SUID-CR Workgroup. Staff from the MIEC Home Visiting Program have all been trained by the SIDS Center of NJ and will promote the infant safe sleep message during their visits to over 6,000 families annually in NJ.

In November 2014 as part of the SUID-CR grant infant safe sleep training was provided to First Responders to provide healthy infant sleep education to the people they serve. The training called DOSE (Direct On Scene Education) significantly reduced the number of sleep related infant deaths in Ft. Lauderdale, Florida. After an emergency is handled and the home is identified as having a resident infant, the first responder can ask to see where the infant sleeps. Upon observation of the infant's sleep environment the first responder can make recommendations to improve upon the environment and provide pamphleted information to caregivers. Caregivers are likely to buy-in to the education provided by First Responders since they are widely regarded as heroes and experts in the field of health and safety. With grant funding the DOSE program training was provided during a conference to management level EMT and Fire personnel. The personnel that received the training, in turn, will educate their staff thus reaching a large number of people. The training was centrally located allowing for personnel from all over the state to attend. The training program addressed all risk and protective factors developed by the American Academy of Pediatrics.

In 2015, as part of the SUID-CR grant, the SUID Sub Committee partnered with Cribs for Kids and distributed over 700 "survival kits" to family success centers as well as child care resource and referral centers located throughout the state. Family success centers and child care resource and referral centers were targeted as these are locations where families regularly seek out assistance and resources. Each child care resource and referral center set up an exhibit of a safe sleep environment. Contained within the

survival kits were a pack and play, Halo sleep sack, safe sleep information and age appropriate pacifiers. The SUID Sub Committee also distributed children's books by Dr. John Hutton entitled "Sleep Baby, Safe and Snug" to all 46 local child protection offices in both English and Spanish. These books were shared with mothers of newborns and pregnant mothers to educate about safe sleep practices in an easy to understand way while also encouraging bonding between mother and child through reading. The SUID Sub Committee also utilized grant funds to provide public education on safe sleep practices that reduce the risk of sleep related death in infants through the use of advertisements within NJ Transit. Throughout the state the advertisements were featured on NJ Transit buses and light rails as well as on train station platforms focusing specifically on the high incidence areas identified through SUID data. The advertisements began at the end of September 2015 and continued through the end of the year.

Currently, the SUID Subcommittee is in the process of creating a safe sleep educational video that will be featured on the Department of Children and Families webpage. The video includes excerpts from safe sleep experts as well as a safe sleep environment modeled by a father. The SUID Subcommittee realizes how important the role of the internet is in today's society and is hopeful that the safe sleep message reaches a large audience through the internet.

Plan for the Application Year SPM 1: (*The percentage of Black non-Hispanic preterm births in NJ)*

	2005	2006	2007	2008	2009	2010	2011	2012
Annual Indicator	11.5	12.1	11.3	11.0	10.6	10.0	9.9	10.0
Numerator	1,866	2,039	1,945	1,861	1,744	1,577	1,489	1,540
Denominator	16,221	16,864	17,256	16,858	16,507	15,779	14,992	15,475

Notes - Source of provisional 2012 data is the Electronic Birth Certificate file which includes births in NJ to out-of-state residents and does not include births to NJ residents outside of NJ.
See Chart 5 Low Birthweight by Race/Ethnicity attached as Supporting Document #3.

The selection of SPM #1 (The percentage of Black non-Hispanic preterm births in NJ) during the Five-Year Needs Assessment process recognizes the persistence of racial/ethnic disparities in healthy birth outcomes in NJ. Infants who are born preterm are at the highest risk for infant mortality and morbidity. The percentage of black preterm births was selected to begin to address the underlying causes of black infant mortality and the racial disparity between preterm birth rates.

Maternal and Child Health Services has a long history of addressing perinatal health disparities with special emphasis on the Black Infant Mortality Reduction Initiative which was initiated in 1985. In February 2008 a Commissioner's Prenatal Care Task Force was convened to make recommendations to improve access to prenatal care in NJ. Health disparities was identified as a priority. The overall goal of the Access to Prenatal Care Initiative was to increase the rate of first trimester prenatal care in NJ to at least 90% to coincide with the National Healthy People 2010 goal, with emphasis on racial and ethnic disparities.

The Improving Pregnancy Outcomes (IPO Initiative) will develop partnerships with community-based maternal and child health providers/agencies with proven capabilities in implementing activities/interventions within a targeted community and the capability to focus on reproductive-age women and their families. The goal of this IPO initiative is to improve maternal and infant health outcomes for high-need women of childbearing age and their families, while reducing racial, ethnic and economic disparities in those outcomes through a collaborative coordinated community-driven approach. County-based consumer-driven advisory groups for the IPO Initiative and the Central Intake Hubs will meet quarterly to build partnerships and local referral systems.

Thirteen grants were awarded in 2014 for the Community Health Worker (CHW) model. CHWs are paraprofessionals who are trusted members of the target community to whom other community members turn for a variety of social supports. The focus of the IPO Initiative is to increase the number of women receiving preconception care as well as earlier and regular prenatal care, increase parenting education, and increase the number of women and children receiving primary care and health promotion.

Seven grants were awarded in 2014 for the Central Intake model which focuses on strategic efforts to assure that the specific needs of individual and families are identified and addressed effectively within community-wide service systems. Both models will be using the Perinatal Risk Assessment (PRA) and the Community Health Screening tool. The goal of risk assessment is to prevent or treat conditions associated with poor pregnancy outcome and to assure linkage to appropriate services and resources through referral. In July 2015 CI was expanded to cover all 21 NJ counties.

NJDOH will continue to partner with the March of Dimes NJ Chapter in the Healthy Babies are Worth the Wait, a program to reduce preterm births among African American women in Newark.

The Department's commitment to reduce black infant mortality will continue through the NGA on Improving Birth Outcomes, the IM CoIIN, the MIECHV Program, and the current Improving Pregnancy Outcomes Initiative.

Annual Report - NPM 4:
4A) Percent of infants who are ever breastfed and
4B) Percent of infants breastfed exclusively through 6 months

FHS has supported Baby-Friendly™ designation through training, technical assistance and mini-grants. The Baby-Friendly Hospital Initiative (BFHI) is a global program that was launched by the World Health Organization and the United Nations Children's Fund in 1991 to encourage and recognize hospitals and birthing centers that offer an optimal level of care for infant feeding and mother/baby bonding. BFHI recognizes and awards birthing facilities who successfully implement the Ten Steps to Successful Breastfeeding (i) and the International Code of Marketing of Breast-milk Substitutes (ii). Four NJ hospitals have earned the "Baby-Friendly" designation. Two of those hospitals were recipients of a $10,000 mini-grant from FHS. Efforts are underway to replicate the BFH Initiative in the remaining NJ delivery hospitals and 27 more hospitals are actively working toward this certification. All 50 NJ maternity hospitals are also receiving training in promoting evidence-based breastfeeding policy and practice.

With a CDC State Public Health Actions Grant, NJDOH and the NJ Hospital Association delivered webinars and technical assistance calls to 18 hospitals and held a Mother-Baby Summit for all delivery hospitals to assist them in addressing barriers to and identifying potential solutions for implementing the Ten Steps to Successful Breastfeeding.

In 2014, FHS updated its report card, "Breastfeeding and New Jersey Maternity Hospitals: A Comparative Report" (posted at http://www.state.nj.us/health/fhs/professional/breastfeeding_report.shtml), with 2013 Electronic Birth Certificate data. The Report is endorsed by the NJ Chapter of the American Academy of Pediatrics (NJ-AAP) and the NJ Breastfeeding Coalition. The goal of the report is to present breastfeeding initiation as a quality of care issue and to promote the included self-assessment tools and model hospital policy recommendations as tools for hospitals to improve their breastfeeding policies and practices.

NJ hospitals strongly participate in the Maternity Practices in Infant Nutrition and Care (mPINC) survey, which is a national survey of maternity care practices and policies conducted by the CDC every two years, beginning in 2007. In 2013, 85% of 54 eligible hospitals participated in the mPINC Survey. NJ has been gradually increasing its mPINC score and has improved its state rank to 18 out of 53 in 2013.

Despite the overwhelming evidence supporting the numerous benefits of and recommendations for exclusive breastfeeding, exclusive breastfeeding rates in the 24 hours prior to hospital discharge in NJ remain low (see Chart 9 of Supporting Document #3), while any breastfeeding (both breastfeeding and formula feeding) rates continued to increase, yielding an overall increase in breastfeeding initiation rates. In 2013, exclusive breastfeeding at hospital discharge statewide was 45.0%, while any breastfeeding (exclusive and combination feeding) was 80.9% according to in-state electronic birth certificate records.

Breastfeeding rates on discharge varied with the minority composition of mothers. Asian non-Hispanic women were most likely to breastfeed (91.8%) while black non-Hispanic women were least likely to

breastfeed (67.0%). White non-Hispanic and Hispanic women initiated breastfeeding at 81.3% and 83.2% respectively.

The exclusive rates were 56.6% for white non-Hispanic women, 41.5% for Asian non-Hispanic women, 34.4% for Hispanic women, and 30.8% for black non-Hispanic women. Further examination of the disparity in these rates will require information of locally available breastfeeding promotional activities, protocols, and the cultural appropriateness of those services.

WIC Services provides breastfeeding promotion and support services for WIC participants through grants to all 17 local WIC agencies. International Board Certified Lactation Consultants and breastfeeding peer counselors provide direct education and support services, literature, and breastfeeding aids, which include breast pumps, breast shells and other breastfeeding aids. WIC staff conducts the *Loving Support*© Through Peer Counseling Breastfeeding Program. WIC breastfeeding staff conducts professional outreach in their communities and education to healthcare providers who serve WIC participants.

Existing FHS programs that promote breastfeeding and include performance measures for increasing breastfeeding include the Improving Pregnancy Outcomes Initiative and the MIEC Home Visiting Program. In SFY 2013, 66.2% of mothers with 6-week-old infants participating in the MIEC Home Visiting Program were breastfeeding.

Close collaboration between Maternal and Child Health Services (MCHS), WIC Services (WIC), and Community Health and Wellness Services is ongoing. All three programs have an interest in breastfeeding protection, promotion and support and have similar constituencies.

In January 2014, the State finalized new Hospital Licensing Standards that require hospitals to develop and implement evidence-based written policies and procedures for obstetrics, perinatal and postpartum patient services, newborn care, the normal newborn nursery, and emergency departments that address breastfeeding and supporting the needs of a breastfeeding mother and child from the point of entry into the facility through discharge. These Standards support the Ten Steps to Successful Breastfeeding.

The NJDOH will call attention to NJ's second worst rate in the nation (28.4%, with a Healthy People 2020 Target of 14.2%) for hospitals supplementing breastfed infants with formula before two days of life and draw attention to the Joint Commission Perinatal Care Core Measure on Exclusive Breast Milk Feeding, which required hospitals with at least 1,100 deliveries to adopt the performance measure for exclusive breastmilk feeding as of January 1, 2014.

Annual Report NPM #5 (infant safe sleep)

To promote infant safe sleep (NPM #5), NJDOH has supported the evidence-based strategies of the American Academy of Pediatrics, the NICHD's Safe to Sleep Campaign, the activities of the SIDS Center of New Jersey, and the work of the Sudden Unexpected Infant Death Case Review (SUID-CR) Workgroup. To improve the surveillance of infant safe sleep practices, FHS conducts the PRAMS survey which includes questions on infant safe sleep and participates on the SUID-CR Workgroup.

The SIDS Center of New Jersey (SCNJ) is a program funded by the NJDOH at Robert Wood Johnson Medical School, a part of Rutgers, The State University of New Jersey, New Brunswick and the Joseph M. Sanzari Children's Hospital at Hackensack University Medical Center, Hackensack. SCNJ was established in 1988 through the SIDS Assistance Act. The SCNJ mission is to: 1) provide public health education to reduce the risk of sudden infant death, 2) offer emotional support to bereaved families, and 3) participate in efforts to learn about possible causes of and risk factors associated with sudden infant deaths, including those classified as Sudden Infant Death Syndrome.

SCNJ works with parents, grandparents, physicians, nurses, the child care community, hospitals, first responders, schools, social service agencies, health and education programs and state, federal and national organizations to reduce infant mortality and the racial and ethnic disparities associated with it. SCNJ follows the guidelines of the AAP when providing risk reduction education. The Safe Infant Sleep

guidelines of the AAP are intended to help families reduce the risks that are associated with Sudden Unexpected Infant Deaths including Sudden Infant Death Syndrome and Accidental Suffocation and Strangulation in Bed. Research conducted by the SCNJ contributed to these recommendations. Since the SCNJ was established, the rate of SIDS in New Jersey has been reduced by 75%.

NJ has participated in the Sudden Unexpected Infant Death Case Review (SUID-CR) Registry grant funded by the CDC since 2006. SUID-CR activities have standardized and improved data collected at infant death scenes and promoted consistent case review, classification and reporting of SUID cases. NJDOH is represented on the multi-disciplinary SUID-CR Review Board which meets monthly as a subcommittee of the Child Fatality and Near Fatality Review Board (CFNFRB). The SUID-CR is staffed by the Department of Children and Families and is an important statewide surveillance system for unexpected infant deaths. The SUID-CR makes recommendations to the statewide CFNFRB concerning safe sleep and promotes SUID prevention activities.

In 2013 and 2014 the DCF Child Death Review (CDR) Unit, on behalf of the Child Fatality and Near Fatality Review Board, and in partnership with DCF's Division of Community and Family Partnerships, the NJ Departments of Education and Health, and the federal Centers for Disease Control and Prevention, conducted two Sudden Unexpected Infant Death (SUID) prevention activities: the Practicing Healthy Infant Sleep Environments (PHISE) Poster Contest and Tote Bag Giveaway.

The CDR unit distributed 4,500 tote bags filled with educational materials on "Healthy Sleep" practices for infants to Federally Qualified Health Centers (FQHCs), Family Success Centers (FSCs) and Home Visiting (HV) Programs across the state. Specific FSCs, FQHCs and HVs were identified based on the populations they serve (do they serve pregnant women and infants?) and their locations (are they in an area with a high incidence rate of sleep-related infant deaths?). Every county in New Jersey received a share of the tote bags proportionate to the incidence of sleep-related infant deaths in their county. Earlier in the year the CDR unit held a poster contest in NJ middle schools; students were asked to create "Healthy Sleep" posters based on the guidelines established by the American Academy of Pediatrics. The tote bags included a children's book by Dr. John Hutton entitled, "Sleep Baby, Safe and Snug," which addresses healthy sleep practices in a gentle, easily understood manner. Also included in the tote bag was a SleepSack: an infant sleeper-pajama with a built-in blanket and swaddling cloth, produced by Halo Innovations, Inc. The PHISE Poster Contest and Tote Bag Giveaway helped raise awareness of healthy infant sleep environments and practices among a broad swath of New Jersey's citizens: students, educators, healthcare providers, social workers, and parents.

Through the multiple evidence-based strategies in NJ to promote infant safe sleep and the consistent message to place infants to sleep on their backs, NPM #5 has been slowly improving from 57.8% in 2003 to 70.1% in 2012 according to NJ PRAMS data. The SUID rate has also declined from 0.8 per 1,000 live births in 2000 to 0.3 per 1,000 in 2012 according to the NCHS. Racial and ethnic disparities in NPM 5 persist and are being addressed through more targeted educational messages using home visitor staff in DCF and the MIEC Home Visiting Program.

Annual Report – SPM #1

The Department's commitment to reduce black infant mortality and preterm births has been demonstrated through the Blue Ribbon Panel on Black Infant Mortality Reduction, the Black Infant Mortality Reduction Advisory Council, the BIBS campaign, the Commissioner's Prenatal Care Task Force, the Access to Prenatal Care Initiative, the ASTHO Prematurity Pledge, the MIECHV Program, the NGA on Improving Birth Outcomes, the IM CoIIN, and the recent Improving Pregnancy Outcomes Initiative.

II.F.1.c. Child Health

The domain of Child Health includes the State Priority Needs of #3 Improving Nutrition and Physical Activity and the selected National Performance Measures of #6 Developmental Screening and #8 Physical Activity and State Performance Measure #2 (Blood Lead Screenings). NPMs #6, NPM #8 and

SPM #2 were selected during the Five-Year Needs Assessment process for their impact on overall child health and for the evidence-based strategies implemented by NJDOH and its partnerships.

Plan for the Application Year - NPM #6: *(*Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool)

	2007	2011-2012
6: Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool	12.67	25.02

Source – National Survey of Children's Health (NSCH)

Increasing NPM #6 is an important focus in the domain of Child Health to improve overall child health and well-being. Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home. The percent of children with a developmental disorder has been increasing, yet overall screening rates have remained low. The American Academy of Pediatrics recommends screening tests begin at the nine month visit.

The NJDOH will continue to participate as an interdepartmental partner active with the NJ Council for Young Children (NJCYC), the Race to the Top-Early Learning Challenge (RTTT-ELC) grant and CDC's 'Learn the Signs' NJ Team. The NJCYC, Infant Child Health Committee has established a priority of improving system connections for children and families with health care providers, community services, early intervention, child care, home visiting to expand screening (prenatal and child development) in health care and early care and education settings. Grow NJ Kids (GNJK) a Quality Improvement Rating System (QRIS) developed for early learning programs requires the use of a "state approved" developmental screening at Level 2 of a 5 level rating with the expectation that 90% of high needs infants and children participating in GNJK will receive developmental screening by 2018 with an emphasis on using the parent completed child monitoring system Ages and Stages Questionnaires (ASQ and ASQ: SE) screening tools.

The MIEC Home Visiting Program will continue to promote and monitor parent completed child development screening tools (ASQ and ASQ: SE). In SFY 2014 over 6,837 families with young children participated across all 21 NJ counties. Developmental screening is a required benchmark performance measure and improving developmental screening practices and policies is a current focus on HV evaluation and continuous quality improvement.

NJ has completed a significant amount of work to create an aligned system of early education data through the NJ-EASEL (New Jersey Enterprise Analysis System for Early Learning). The NJ-EASEL project will link DOE's Statewide Longitudinal Data System (NJ SMART), DCF's Licensing System, DHS's Workforce Registry (New Jersey Registry for Childhood Professionals, a component of the Grow NJ Kids data system), DHS's child care system (CASS), DCF's foster care system (NJ SPIRIT), DOH's Early Intervention System (NJEIS), DCF's Home Visiting system, Head Start/Early Head Start program data systems, and other state early learning and development data collections within the parameters of state and federal privacy laws. NJ-EASEL project is designed to be able to measure outcome objectives of the RTTT-ELC including being able to show that early developmental screening has a direct impact on identifying children and referring them to needed services resulting in positive outcomes for children. The NJ-EASEL data warehouse will serve as the repository through which collected data informs the quality improvement and outreach activities "managed" by GNJK.

Plan for the Application Year - NPM #8: *(*Percent of children ages 6 through 11 and adolescents ages 12 through 17 who are physically active at least 60 minutes per day)

	2003	2007	2011	2013
8a: Percent of children ages 6 through 11 who are physically active at least 60 minutes per day	23.6	35.5	27.6	
8b: Percent of adolescents ages 12 through 17 who are physically active at least 60 minutes per day	19.0	23.0	23.2	27.6*

Source – National Survey of Children's Health (NSCH)
*Source – CDC, National Center for Health Statistics

Increasing NPM #8 is an important focus in the domain of Child Health to prevent obesity and improve overall child health and well-being. FHS has been collaborating on and developing partnerships to address this NPM thru ShapingNJ and the CDC WSCC model. Regular physical activity can improve the health and quality of life of Americans of all ages. Physical activity in children and adolescents reduces the risk of early life risk factors for cardiovascular disease, hypertension, Type II diabetes, and osteoporosis. In addition to aerobic and muscle-strengthening activities, bone-strengthening activities are especially important for children and young adolescents because the majority of peak bone mass is obtained by the end of adolescence.

FHS recognizes that positive physical activity and nutritional practices start at a young age and should be addressed as early as possible. Children at greatest risk for overweight and obesity as well as physical inactivity are concentrated in disadvantaged communities. Among the 44 states reporting on low-income childhood obesity, NJ has the highest prevalence in children 2 to 5 years of age at 14.2%, according to the 2011 WIC Pediatric Nutrition Surveillance System.

ShapingNJ, the state public-private partnership for nutrition, physical activity and obesity prevention consists of some 230 organizations working to reduce and prevent obesity in NJ. The work is focused in 6 settings, including early care and education, schools, communities, work sites, health care and faith-based. Funded by the Nemours Foundation, work in the early care and education setting focuses on embedding obesity prevention strategies (access to healthy food, physical activity, reduction of screen time and breastfeeding support) in the larger agenda for NJ's youngest through training and close collaboration with other state lead agencies. In the communities, the NJ DOH is part of a funding collaborative that together supports 45 NJ at-risk communities charged with implementing one healthy food access strategy and one physical activity strategy (***ShapingNJ*** strategies) through policy and environmental change. The NJDOH also funds Faith in Prevention, an initiative charged with engaging faith-based organizations in the battle against chronic disease in Trenton, Camden and Newark.

School health objectives aim to: Provide training and technical assistance from 75 of the State's 600+ school districts (K -12) in 2016 to 100 by 2017 to create school environments that provide healthy nutrition and opportunities for physical activity throughout the day including quality physical education.

- New Jersey Association for Health, Physical Education, Recreation and Dance (NJAHPERD), with CDC funding, conducts professional development sessions at statewide and regional meetings on: Physical Education/Physical Activity for K-12 teachers; School Food Service guidelines and nutrition standards for K-12 teachers; Preparing fresh fruits and vegetables for School Food Service staff.

- Center for Supportive Schools (CSS), with funding from the CDC, has convened a statewide school health advisory committee to provide guidance on the development of a model school district *Wellness Policy* and is developing a plan to promote the policy to school districts and other school stakeholders.

- The New Jersey State Alliance of the YMCA, with CDC funding, continues to provide intensive training and technical assistance in five low-income school districts (including five - K-8 schools per district for a total of 25 schools; 1 high school per district in three districts = 3 high schools) to implement Comprehensive School Physical Activity and improve school nutrition environments.

- Health Corps, with State MCH block funding, supports efforts targeting three high schools. This funding supports three, full time, school-based youth coordinators to serve as peer mentors at the three high school sites to implement nutrition, physical activity and healthy lifestyles activities with students, teachers and the greater surrounding community.

Other nutrition, physical fitness and obesity prevention initiatives within the Office of Tobacco Control, Nutrition and Fitness (OTCNF) that are funded by the CDC - "State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health" support breastfeeding initiation, duration and exclusivity for the first six months of life and healthy communities.

- New Jersey Hospital Association (NJHA) - The OTCNF provides funding to the NJHA to continue training and technical assistance to eighteen of the 52 NJ maternity hospitals to help move them towards implementation of the WHO/UNICEF's "Ten Steps to Successful Breastfeeding", a program designed to promote exclusive and sustained breastfeeding. In May 2015 and again in September 2016, NJHA will convene a statewide training summit for all NJ maternity hospitals. Birthing facilities utilize the 2015 document published by NJHA titled: Healthy Beginnings NJ: *Supporting Breastfeeding Moms and Babies Technical Assistance Guide for Hospital Providers*.

- New Jersey Prevention Network (NJPN) - The OTCNF provides funding to NJPN's *Get Active NJ* program which provides technical assistance, training and incentives to assist municipalities to find ways to educate stakeholders on different policies that can promote walking and the many benefits that walking may have on their communities. The *Get Active NJ* - Walkability Toolkit created by NJPN, is intended to provide information and examples on how local policies are created at the municipal level to support walkability.

- The Food Trust - The OTCNF contracts with The Food Trust to implement activities and projects to promote policy and environmental change for obesity prevention in local communities. Trainings and technical assistance are provided to corner store owners in order to increase community residents access to healthy foods and beverages, particularly those at high-risk for obesity and other chronic disease. The Food Trust provides on-site technical assistance to a minimum of 20 small retailers to promote healthy retail sales in their stores. Corner stores are targeted through a collaboration with the NJ Department of Health WIC Program, the Community Health and Wellness Unit - OTCNF and The Food Trust. Beyond requiring WIC authorization, participating stores must be located in a food desert as defined by USDA.

The work of the New Jersey Partnership for Healthy Kids (NJPHK) supports Robert Wood Johnson Foundation's (RWJF) six policy priorities for improving nutrition and increasing opportunities for physical activity, both of which are critical to reversing the childhood obesity epidemic. NJPHK is a statewide program of the RWJF with technical assistance and direction provided by the NJ YMCA State Alliance. The goal of the program is to convene, connect and empower community partnerships across the state to implement environment- and policy-changing strategies that prevent childhood obesity. Community coalitions in Camden, New Brunswick, Newark, Trenton, and Vineland are leading these efforts.

The six policy priorities are:
1. Ensure that all foods and beverages served and sold in schools meet or exceed the most recent dietary guidelines.
2. Increase access to high-quality, affordable foods through new or improved grocery stores and healthier corner stores and bodegas.
3. Increase the time, intensity and duration of physical activity during the school day and out of school programs.

4. Increase physical activity by improving the built environment in communities.
5. Use pricing strategies – both incentives and disincentives – to promote the purchase of healthier foods.
6. Reduce youth exposure to unhealthy food marketing through regulation, policy and effective industry self-regulation.

Since the start of (SJfS) in the Fall of 2014, 170 districts and 438 schools have registered for certification. Through the regional school health grantee's partnership with SJfS, NJ schools are working on a variety of actions that contribute toward increasing physical activity and/or improving the built environment. The actions are listed below with the number of schools working on the action and, the number approved in meeting action's standards.

Health and Wellness Action	# Schools Working on Action	# Schools Approved
Pedestrian and Bicycle Safety and Promotion Initiatives	15	3
Policies to Promote Physical Activity	12	0
Programs to Promote Physical Activity	21	3
Safe Routes to School District Policy	11	0
School Travel Plan for Walking and Biking	13	3

The partnership with Nemours Foundation will continue (funding period 2013-2018) with additional learning collaboratives being launched. Efforts will be planned to integrate this work with the work of other State Departments (Agriculture, Children and Families, Education and Human Services). Child care toolkits to assist providers in improving nutrition and physical activity practices will be disseminated.

Plan for the Application Year - SPM #2: *The percentage of children with elevated blood lead levels (≥10 ug/dL).*

SPM #2 was selected to address the issue of childhood lead poisoning which is not specifically addressed by the NPMs or NOMs. Long-term exposure to lead can cause serious health problems, particularly in young kids. Lead is toxic to everyone, but unborn babies and young children are at greatest risk for health problems from lead poisoning — their smaller, growing bodies make them more susceptible to absorbing and retaining lead. Lead exposure can cause permanent damage to the brain and nervous system, resulting in learning, behavioral, and hearing problems, as well as slowed growth and anemia. Children with elevated blood lead levels are at increased risk for behavioral problems, developmental delays, and learning disorders. Increased childhood morbidity will result from undetected and untreated lead poisoning.

The CDC Cooperative Agreement Year 1 outcomes determined data-driven primary prevention interventions for Year 2 that are implemented by not only the NJDOH, but its strategic partners and lead and healthy homes grantees. Performance management strategies were incorporated at the Program level to ensure data-driven, evidence-based practices are used. Formal evaluation of the Superstorm Sandy recovery project will be undertaken so that lessons learned can be shared throughout the state.

Child Health

Annual Report - NPM #6: *(*Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool)

The NJDOH is an interdepartmental partner active with the NJ Council for Young Children (NJCYC), the Race to the Top-Early Learning Challenge (RTTT-ELC) grant and CDC's 'Learn the Signs' NJ Team. The NJCYC, Infant Child Health Committee has established a priority of improving system connections for children and families with health care providers, community services, early intervention, child care, home

visiting to expand screening (prenatal & child development) in health care and early care & education settings. Grow NJ Kids (GNJK) a Quality Improvement Rating System (QRIS) developed for early learning programs requires the use of a "state approved" developmental screening at Level 2 of a 5 level rating with the expectation that 90% of high needs infants and children participating in GNJK will receive developmental screening by 2018 with an emphasis on using the parent completed child monitoring system Ages and Stages Questionnaires (ASQ and ASQ: SE) screening tools.

The Boggs Center on Developmental Disabilities, NJ's federally-designated University Center of Excellence on Developmental Disabilities, and the Statewide Parent Advocacy Network (SPAN), the state's federally-designated Parent Training and Information Center (PTI) and Family to Family Health Information Center (F2F) collaborated on the Act Early State Systems Grant with the shared goal of improving access to developmental screening and referral among underserved children in NJ. One of three overarching objectives of this project included strengthening the collaborative efforts between The Boggs Center and SPAN within the scope of promoting developmental screening using validated instruments at appropriate intervals as well as referral for diagnosis, Early Intervention, and community services and supports at NJ's network of FQHCs and community clinics.

Over the project period, SPAN and The Boggs Center partnered to provide 15 parent-led trainings about developmental screenings to healthcare providers at FQHCs throughout the state, attended by a total of 195 participants. Overall, 7 trained SPAN Family Resource Specialists, each with a child on the autism spectrum, participated in the project and a total of 27 SPAN parents were represented at the 15 trainings. Early Intervention representatives presented at 9 of the 15 trainings; all but one were parents and one was a sibling.

NJ is part of a national Project LAUNCH initiative designed to promote the wellness of young children ages birth to 8, and reduce racial and ethnic disparities including an emphasis on routine developmental screening. NJ Project LAUNCH is targeting urban Essex County and is using a Help Me Grow systems approach to strengthen the connections between physicians, parents/families, and community providers to addresses the physical, social, emotional, cognitive, and behavioral aspects of child development. Project LAUNCH ensures that parents/families have access to a continuum of community-based evidence-based programs (EBP) that support parent-child interaction and young child development across a range of settings—health care, home visiting, child care, Early Head Start/Head Start, preschool/school to promote early identification of health and developmental issues that impact child wellness.

Annual Report - NPM # 8: Percent of children ages 6 through 11 and adolescents ages 12 through 17 who are physically active at least 60 minutes per day

The ShapingNJ child care workgroup has collaborated on a number of systems efforts. Child care partners continue to offer training and technical assistance at county and statewide trainings to increase center staff capacity for best practices that will prevent obesity in our most vulnerable population. Beginning in April 2013, NJ received funding from Nemours Foundation as part of a six-state early care and education learning collaborative to ensure that licensed child care providers offer children healthy food, breastfeeding support and opportunities for active play. One hundred licensed centers serving 100 or more children were enrolled. Participation in this project will assist centers meet and exceed new licensing requirements. New licensing requirements were adopted by the Office of Licensing (Department of Children and Families) and became effective September 30, 2013 (http://www.state.nj.us/dcf/providers/licensing/laws/CCCmanual.pdf). Sustainability efforts can be achieved through participation in a six-state early care and education learning collaborative coordinated by the Nemours Foundation and funded by CDC. A state coordinator was hired to work within the NJDOH and five regional learning collaboratives were established in NJ in year one of a five-year funding that focused on improving skills of child care center staff.

The Child Care Workgroup of ShapingNJ developed and distributed a best practices toolkit to partners at the annual ShapingNJ meeting in June 2013 and was shared with county-level partners through the

Office of Local Public Health for more rapid dissemination. It is also posted on the ShapingNJ.gov website.

Annual Report - SPM # 2: *The percentage of children with elevated blood lead levels (≥10 ug/dL).*

Meaningful progress was made toward SPM # 2 in CY 2014. More than 225,000 blood lead tests were reported on 209,068 children <17 years of age. Of the children tested during CY 2014, 84.1% were under the age of 6 years. Among these children, 0.50% had results ≥10 ug/dL and 3% had results ≥5 ug/dL. Of all the children tested, 95,003 were between six months and 26 months of age, the ages at which State regulations require children to be screened for lead poisoning. This represents 42.2% of all children in that age group. Looking at all blood lead tests reported since 1999, it is estimated that 79% of children have had at least one blood lead test before the age of three years, and 60% of children have had at least one blood lead test before the age of 2 years.

Table SPM #2

	CY 2010	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015
*The percentage of *children with elevated blood lead levels (≥10 ug/dL).*	0.7	0.6	0.5	0.5	0.5	0.5
Numerator*	1,236	1,103	898	793	816	876
Denominator*	185,055	182,040	183,215	176,847	171,521	175,878
Is the Data Provisional or Final?	Final	Final	Final	Final	Final	Provisional

*Children ≤6 years of age
Notes - Source: Childhood Lead Poisoning Information Database, MCHS, FHS.

The web-based data and surveillance system, LeadTrax, containing case management and environmental investigation modules continues to be customized, and remained compliant with CDC data requirements. The LeadTrax users base increased as the database was tailored to include a Healthy Homes module, HomeTrax. Strategic partnerships with home visitation and housing inspection programs enabled new users to be trained and given tiered access to HomeTrax. Efforts focused on identifying and addressing health and safety hazards where young children reside.

Ongoing efforts to increase the percentage of laboratories reporting electronically resulted in an increase from 99.58% in CY 2014 to 99.60% in CY2015. NJDOH continued to assist the remaining laboratories to transition from reporting on hard copies to electronic reporting. NJ has legislation that requires the lead screening of all children. Every primary care provider and health care facility that provides care to children less than six years of age is required to comply with the law.

Collaborative efforts with Medicaid and its contracted managed care providers continued in order to monitor and increase the number of Medicaid-enrolled children screened for lead poisoning. The LeadTrax records are matched biannually to the Medicaid Eligibility file to identify lead screening rates and unscreened Medicaid participating children. The LeadTrax lead testing results are included in the NJ Immunization Information System (NJIIS) to provide healthcare providers with lead screening results and histories.

Monitoring of the Elimination Plan continued to be coordinated by NJDOH to assure that the state is collectively making progress to eliminate childhood lead poisoning. In addition, a Healthy Homes Strategic Plan that was developed to expand the State's focus to other housing hazards that affect the

health of all residents was implemented. Training opportunities for professionals were made available through the NJ Healthy Homes Training Center, a public-private partnership between NJDOH and Isles, Inc, a Trenton-based, non-profit, community development agency.

In New Jersey's largest city, Newark, the Newark Department of Health and Community Wellness, continued to administer the Newark Partnership for Lead Safe Children. Three other local agencies continued to administer Regional Lead and Healthy Homes Coalitions with statewide outreach and a focus on primary prevention.

NJDOH is incorporating a healthy homes approach into its services provided by local health departments that provide case management and environmental intervention services for children with elevated blood lead levels. Training on healthy homes principles for staff of local health departments and home visitation-based programs in the Department of Children and Families (DCF) continue. DCF's Home Visiting programs, funded in part by NJ's MIEC Home Visiting Grant, provide services to pregnant women, infants, and young children. In addition, staff that assess the suitability of homes for placement of children who have entered foster care or are registered as family child care homes were targeted for training. Emphasis is placed on developing strategic partnerships with additional home visitation and government-funded home inspection agencies that serve highest-risk, hard to reach populations as identified in the Healthy Homes Strategic Plan. A CDC Cooperative Agreement, awarded in October 2014, focuses on childhood lead poisoning surveillance to determine key indicators to evaluation areas of progress and deficiencies. Through funding provided by the Social Services Block Grant, the NJDOH is providing lead and healthy homes related services as NJ continues to recovery from Superstorm Sandy. The major components are public education, professional trainings, targeted blood lead screenings and public health nurse intervention, and dust and soil sampling of highest-risk communities to identify lead hazards.

II.F.1.d. Adolescent / Young Adult Health

The domain of Adolescent/Young Adult Health includes focuses on NPM #10 (Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year), NPM #11 (Percent of children with and without special health care needs having a medical home) and NPM #12 (Percent of children with and without special health care needs who received services necessary to make transitions to adult health care). Because reporting on NPM #11 and #12 overlap the two domains of Adolescent/Young Adult Health and SCHCN, the narrative for NPM #11 and #12 will be presented in this Adolescent/Young Adult Health section and not repeated in the CYSHCN Section. This section serves as the state's narrative plan for the Application year and as the Annual Report for the reporting year. Planned activities for the Application year are described and programmatic efforts summarized that have been undertaken for the Annual Report year, with primary emphasis placed on the performance impacts that have been achieved. The strategies and activities to address the identified priorities from the Needs Assessment Summary are further described.

Plan for the Application Year - NPM #10:

Improving NPM #10 (Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year) is an important performance measure in the domain of Adolescent/Young Adult Health and is related to SPM #4 Promoting Youth Development. Receiving health care services, including annual adolescent preventive well visits, helps adolescents adopt or maintain healthy habits and behaviors, avoid health-damaging behaviors, manage chronic conditions, and prevent disease.

The patient-centered medical home is a way of organizing primary care that emphasizes care coordination and communication to improve patients' and providers' experience of care and the quality of care for all children. Promotion of the medical home is a strategy to improve NPM # 10 (Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year). Providing a medical home means offering care that is accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective (AAP, Policy Statement, July 2002). A medical home is a place where care for the child and adolescent is centralized, coordinated and monitored. A team approach to medical home improvement includes engaged staff members and parents as key improvement partners.

NJAAP has identified the medical home as one of 8 key issues to address to improve pediatric care in NJ. Since 2009, NJAAP, NJ DOH and other partners have been working to increase primary care team education and awareness about the medical home to promote prevention, wellness and chronic care management. With the opportunity for NCQA Recognition as a patient centered medical home, NJAAP's support has enabled participating practices to assess their current level of "medical homeness" using the Medical Home Index, and additionally has engaged their participation in various QI activities.

The plan for the applicant year for NPM #10 is to continue the Medical Home Technical Assistance Program for 2015-2016 "Improving Population Health Management" which proposes that the NJAAP, in partnership with the Statewide Parent Advocacy Network (SPAN) and the NJDOH, implemented HRSA's Integrated Systems Grant (ISG) to improve access to quality, culturally competent, family centered systems of service for children, especially children with special health care needs. This support for the Medical Home Initiative enabled NJAAP to work with over 30 practices in 13 counties across NJ in the development of practice teams and utilization of the model for improvement to strengthen patient centered medical homes.

The Medical Home Technical Assistance Program for 2015-2016 "Improving Population Health Management" which is granted funded by FHS will provide in-depth Technical Assistance for 5 Pediatric Practice teams, raise awareness for patient centered medical home including "Triple Aim", and address the needs identified through a recent survey,

Table NPM 10

	2003	2007	2011-2012
Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year	84.11	94.54	93.27

Source – National Survey of Children's Health (NSCH)

Plan for the Application Year - NPM #11: Percent of children with and without special health care needs having a medical home

Adolescence is a period of major physical, psychological, and social development. As adolescents move from childhood to adulthood, they assume individual responsibility for health habits, and those who have chronic health problems take on a greater role in managing those conditions. Receiving health care services, including annual adolescent preventive well visits, helps adolescents adopt or maintain healthy habits and behaviors, avoid health-damaging behaviors, manage chronic conditions, and prevent disease. Providing comprehensive care to children in a medical home is the standard of pediatric practice which should be delivered within the context of a trusting and collaborative relationship between the child's family and a competent health professional familiar with the child and family and the child's health history. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care and immunizations, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions.

The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. Ideally, medical home care is delivered within the context of a trusting and collaborative relationship between the child's family and a competent health professional familiar with the child and family and the child's health history. Providing comprehensive care to children in a medical home is the standard of pediatric practice. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care and immunizations, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions. The Maternal and Child Health Bureau uses the AAP definition of medical home. State staff continues to develop refined techniques within the electronic reporting system (i.e., CMRS) that will include all seven qualities essential to medical home care.

CSHCN with a medical home has been a priority for the SCHEIS program which has been supported by several partnerships and collaboratives. Having a primary care physician service identified in a child's Individual Service Plan (ISP) developed with an SCHS CM served as a medical home proxy beginning 2014 reporting. It is acknowledged that a medical home is more comprehensive than just having a primary care physician. In part, it is also imperative for a child to have consistent health insurance to increase access to said provider. Of the 19,930 children age 0 to 18 years served in FFY 2015, 3,243 children (approximately 16%) had both a primary care physician and insurance identified in their ISP.

Table NPM 11 - Percent of children with and without special health care needs having a medical home

	2007	2011_2012
Percent of children with special health care needs having a medical home	51.8	42.2
Percent of children without special health care needs having a medical home	57.8	55.4

Data Source: National Survey of Children's Health (NSCH)

A total of seven pediatric/family medicine practices across NJ, representing 126,500 children were recruited to participate in the AAP's Patient Centered Medical Home Technical Assistance program. The

scope of Fiscal Year 2015's project will include continued evaluation of the seven participating practices' status with regard to achieving NCQA Recognition as a Patient Centered Medical Home; review and/or submission of required documentation, feedback for a series of webinars provided and progress made regarding completion of required standards during the 12-month project. The goal for 2015 is to expand and build NJ's capacity by having the NJAAP/Medical Home Quality Improvement Team become NCQA Recognized Experts and by staffing an "NCQA Recognition Warm Line" available to Pediatricians across the State. September 2015, FCCS was awarded a 2 year ISG to increase the percentage of CYSHCN with a medical home by 20%. FCCS is partnering with NJ-AAP, SPAN, and a subset of SCHS CMUs for this project.

Health Service grants funded by RPHS will continue to require agencies to outreach and facilitate enrollment of potentially eligible children into health insurance. The Improving Pregnancy Outcomes Initiative will increase health insurance enrollment by assessing health insurance status and referring uninsured families with adolescents.

State SCHEIS staff will continue to refine tracking of Performance Measures in CMRS and provide documentation training to Special Child Health Services Case Management Units to ensure activities related to these Measures are accurately counted. Changes to CMRS are proposed and in process to modify reporting, data collection, and tracking of medical home components. ISG funding of $15,000 in 2016 and $10,000 in 2017 is proposed to implement these changes to CMRS.

State staffs will continue to share resources and training updates with SPSPs on the reorganization of State programs and services that can influence access to primary and specialty care, including the Comprehensive Waiver, Managed Long Term Services and Supports, and changes in access to care through implementation of the Affordable Care Act. Likewise, continuing to promote linkages between the Medicaid managed care agencies will remain important in supporting families with CYSCHN seeking in-State specialty care.

Title V will continue to support a safety net of specialty providers and case management units. Trends in the utilization of specialty care across the provider network will continue to be monitored by State staffs via onsite monitoring and programmatic reports. Likewise, continued collaboration with network agencies, State agency and community-based partners through the Consortium of Care, and consumers, will continue in an effort to promote linkage for CYSHCN with a medical home.

Plan for the Application Year - NPM #12 (transition to adulthood)

The transition of youth to adulthood has become a priority issue nationwide as evidenced by the clinical report and algorithm developed jointly by the AAP, American Academy of Family Physicians and American College of Physicians to improve healthcare transitions for all youth and families. Over 90% of children with special health care needs now live to adulthood, but are less likely than their non-disabled peers to complete high school, attend college or to be employed. Health and health care are cited as two of the major barriers to making successful transitions.

Table NPM #12: *The percentage of adolescents (12-17) with (and without) special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Annual NPM #12 Indicator	37.9	37.9	37.9	37.9	37.9	41.8	41.8	N/A	12.2	25.3
Numerator									352	1,101
Denominator									2,892	4,385
Is the Data Provisional or Final?	Final	Final	Final	Final	Final	Final	Final		Final	Provisional

Notes - Indicator data for 2005-2012 comes from the National Survey of CYSHCN, a numerator and denominator are not available (N/A). Beginning 2014, the denominator represents all children age 12-17 years served in FFY by Special Child Health Services Case Management Units (SCHS CMU). The numerator reflects the number of children who had at least one of four transition-type services identified in their ISP.

The four possible types of transition to adulthood services identified as proxies were:
1. identification of an adult-level primary care physician (i.e., pediatrician excluded in the current definition),
2. transition-specific services including Division of Developmental Disabilities (DDD),
3. employment, and
4. health insurance.

SCHSC CMUs serve children with special health care needs up to their 22nd birthday. When the age criterion is relaxed to include children age 12 to 21 years, 5,189 children were served in FFY 2015. Of those youth, 1,473 children (approximately 28%) received at least one service to aid in transition to adulthood.

Identification and monitoring of transition to adulthood needs for CYSHCN and their families served through the SCHS CMUs statewide is ongoing. Transition packets as noted above will continue to be updated and shared with families and linkage with community-based supports is provided. State staffs will monitor the SCHS CMUs efforts to in reach and outreach to CYSHCN regarding transition, and documentation of goals related to transition on adolescents' individual service plans. Likewise, efforts to capture the discussion of transition to adulthood between families of CYSHCN and SPSP providers are in process.

The SCHS CMUs and SPSP will continue to facilitate transition to adulthood with youth by ensuring a transition to adulthood goal on the individual service plan. Likewise, exploring youth and their parents' needs to facilitate transition with insurance, education, employment, and housing, and linking them to community-based partners will continue.

SCHS CMUs and pediatric specialty providers will refer youth and/or their parents to New Jersey Council for Developmental Disabilities (NJ CDD) for participation in Partners in Policymaking (PIP) self-advocacy training as well as continue to assist youth and their families to advocate for transitional supports through their individualized education plans and community-based supports. Title V will continue to participate in PIP mock trials to facilitate the development of clients' self-advocacy skills.

Under health care reform, NJ Medicaid eligibility for single adults has expanded in 2014 to up to 133% FPL. As this population is intended to include a significant percentage of childless adults with incomes below 133% of FPL, it is anticipated that CYSHCN transitioning to adulthood will have expanded opportunity to access health coverage through Medicaid, the insurance exchange, and coverage through their parents' insurance through age 26 (or in certain circumstance till age 31). In addition, it is also possible that some youth/young adults with special needs on Medicaid may experience a shift in eligibility to an insurance exchange.

The Arc of NJ's annual Mainstreaming Medical Care Conference has been planned for May 30, 2015. Title V participates on its Advisory Board, and the overarching theme of this year's conference is promoting medical care for persons with developmental disabilities. The integration of behavioral and medical care, work incentives for persons on SSI or SSDI benefits, and Managed Long Term Services and Supports for persons with developmental disabilities are common themes. These key concepts are vital in developing transition planning for many of NJ's CYSHCN and/or their families and SCHS CMU and SPSP providers are encouraged to attend these trainings.

Annual Report - NPM #10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year

From July 2009 through August 2014, NJAAP, in partnership with the SPAN and the NJDOH, implemented HRSA's Integrated Systems Grant (ISG) to improve access to quality, culturally competent, family centered systems of service for children, especially children with special health care needs. This support for the Medical Home initiative enabled NJAAP to work with over 30 practices in 13 counties across NJ in the development of practice teams and utilization of the model for improvement to strengthen patient centered medical homes. The ISG program success was measured utilizing practice pre/post responses on the Medical Home Index (a nationally validated self-assessment tool for measuring "Medical Homeness") Results for participating practices showed an overall increase from pre to post, representing an increase in their overall "Medical Homeness". Receiving recognition for their degree or "Level" of Medical Homeness, was for many practices, the next step after participating in NJAAP's Medical Home Initiative.

In 2015, NJAAP implemented the Patient Centered Medical Home Technical Assistance program to support practices taking the next step toward NCQA Recognition as a Patient Centered Medical Home. The National Center for Quality Assurance (NCQA) recognition as a Patient Centered Medical Home involves a detailed and lengthy process with many standards and elements, including "Must Pass" elements, that busy Pediatric practices find difficult to navigate independently. Attainment of NCQA Recognition as a PCMH provides practices with payment incentives that will support and sustain financing their Medical Homes. Research demonstrates that PCMHs achieve powerful results. The Patient-Centered Primary Care Collaborative recently summarized PCMH demonstration findings that show success in increasing quality while reducing costs (http://www.pcpcc.net/content/pcmh-outcome-evidence-quality).

To build NJ in-house capacity to best support pediatric practices in the NCQA-PCMH process, the NJAAP/Medical Home Quality Improvement Team members attended the 3-day NCQA Content Expert training sessions (1 attended in 2014; 2 attended in 2015) with a goal of becoming NCQA Recognized Content Experts (currently 1 team member is at Certified status). Knowledge gained from attending these classes has allowed team members to better support the NJAAP NCQA Recognition Warm Line" – available (Fall 2014) at (609) 842-0014 for technical assistance with PCMH Recognition.

In addition to expanding in house capacity, through the Patient Centered Medical Home Technical Assistance Program, NJAAP worked with 7 practices across NJ, (representing 126,500 children) utilizing the knowledge gained through the Model for Quality Improvement and by overseeing the policies, processes and procedural changes that many of the practices implemented throughout their participation in the Medical Home Initiative. NJAAP provided technical assistance as several of the participating practices moved toward applying for formal National (NCQA) recognition as a Patient-Centered Medical Home. Given the time commitment required by practices to successfully document and submit their application to NCQA, 4 of the 7 participating practices engaged the use of a PCMH Recognition Consultant, to aid in the process of NCQA application submission, while also engaging our Medical Home team as a resource regarding suggestions for QI projects, review of tools they were using to aid in NCQA submission, selection of Chronic Diseases for population management, MOC credit information, and as an overall medical home information source.

In an effort to assess level of interest and need as to how best our team could support practices along the PCMH continuum, the NJAAP Medical Home team created and distributed a Medical Home Program Survey to the participating practices. Responses point to the need for Care Planning and Care Management within practices that have or will undergo NCQA Recognition.

NJAAP proposes to utilize the Strategies listed below to address the needs identified through our Survey process, for participating practices and for NJ Primary Care Providers:

Annual Report - NPM #11: Percent of children with and without special health care needs having a medical home

All (100%) of CYSHCN referred into NJ Title V's SPSP providers and SCHS CMUs are screened for status of primary care provider and their families are provided with information on how to link with a primary care provider/medical home. The Title V SCHS CMUs and pediatric specialty providers will continue to provide a safety net for families of CYSCHN. An 11% increase in CYSHCN served was noted across SPSP services; 54,492 (SFY 2013) verse 60,530 (SFY 2014).

Demand remains particularly high for comprehensive team evaluation, and some agencies report a 3- to 6-month wait to schedule new clients. To reverse the wait time to schedule a new comprehensive team evaluation, State staffs provide consultation to SPSP agencies. In an attempt to reduce wait time, one CEC recently implemented a pre-appointment call to families of CYSCHN that screened for presenting needs. In some instances, this technique allowed for targeted appointments with specialists rather than a full evaluation, streamlined scheduling, reduced appointment wait time to less than 6 weeks, and opened up appointments that necessitated full team evaluations in a more timely manner. Anecdotally, the agency reported that although their efforts required a slight increase in staffing time it yielded a reduced wait time, and all CYSHCN as well as their referring physicians were provided with service plans. The results of this effort were shared with other CECs, and they are exploring the possibility of replicating it. State programmatic monitoring to ensure that clients have and/or are referred to community-based providers will remain ongoing; chart audits and visits to assess clinic days and provide consultation as well as follow-up telephone support will continue.

Likewise, family input to assess their experience with receiving specialty care through the SPSP providers was sought through a patient satisfaction survey. The survey was developed with parent and provider input, translated into Spanish, tested for cultural competency, and administered at SPSP clinic visits during December 2014. It included questions related to clinic setting/staff as well as medical care; quality of physical evaluations, receipt of clear directions on follow-up care, coordination of services and ratings on services received. Over 800 parents of CYSHCN opted to complete the anonymous self-administered survey, with 17% of responses completed in Spanish. Although some medically complex CYSHCN regularly seek treatment at SPSP clinics; i.e., Tertiary Care providers, many remain under the care of a community-based provider and seek consultation at the SPSP clinics. This collaborative treatment model requires coordination with CYSHCN's medical home. Survey findings are currently under analysis and will be reviewed by Title V staff and used in program evaluation and planning. In addition, findings will be shared with providers for use in self-evaluation. In the interim, preliminary Tertiary care survey data suggests that 70% rated their care coordination as excellent, and 80% indicated that their coordination of services is excellent. Title V anticipates that these family satisfaction findings will support future efforts to improve coordinated care and linkage with medical home.

Title V is committed to collaboration with the DHS Office of Medicaid Managed Care, the COCC, SPAN, and the NJ AAP, and other community-based partners to engage in medical home initiatives to reinforce linkage of CYSHCN with comprehensive community providers. Building upon a Title V-funded medical home pilot project, in July 2009 Title V, in partnership with the NJ AAP and SPAN, implemented HRSA's Integrated Systems Grant (ISG) to improve access to quality, culturally competent, family-centered systems of service for children, especially children with special health care needs. This additional support for the Medical Home initiative enabled NJ AAP to work with over 30 practices in 13 counties across the State in the development of practice teams and utilization of the model for improvement to strengthen patient-centered medical homes. The ISG program success was measured using evaluation of the Medical Home Index (a nationally validated self-assessment tool for measuring "Medical Homeness" that each practice must complete pre and post-program participation). Results for participating practices showed an overall increase from pre- to post, representing an increase in their overall "Medical Homeness." For example, within Domain Six of the Medical Home Index: Quality Improvement, pre-program score for participating practices was a value of 2.4 and post-program score revealed an increase of 1.9 points for a value of 4.3. Receiving recognition for their degree or "Level" of Medical Homeness, is for many practices, the next step after participating in NJ AAP's Medical Home Initiative.

With knowledge gained through the Model for Quality Improvement and with the policies, processes and procedural changes that many of the practices implemented throughout their participation in the Initiative, many of the practices are ready to apply for formal recognition for their efforts, with a goal of payment incentives that will support and sustain financing their Medical Homes. National Center for Quality Assurance (NCQA) recognition as a Patient Centered Medical Home involves a detailed and time-consuming process with many standards and elements, including "Must Pass" elements, that busy Pediatric practices find difficult to navigate independently. Focus for Fiscal Year 2014 was to provide guidance and technical assistance to the practices that were ready to begin this recognition process.

Another example of collaboration on medical home supported by previously funded Integrated Systems Grants (ISG) with SPAN, the NJ AAP, and COCC members in 2012 targeted improvement in access to medical homes for immigrant CYSCHN and their families in three high need/limited English proficiency communities in northern NJ; Passaic, Hudson and Union counties. This project engaged Federally Qualified Health Centers, parents of CYSHCN, and family resource specialists linked with the SCHS CMUs in the above-mentioned counties to promote "medical homeness". Likewise, it promoted navigation skill development for immigrant underserved parents of CYSCHN, and leadership training. Referral to and coordination with in-State specialty care providers was also a component of technical assistance provided to private community-based pediatricians and family practitioners, hospital-based practices, and FQHCs through the ISG medical home project.

In 2014, Title V in collaboration with SPAN, the COCC, the NJ AAP, and other community-based partners, responded to a HRSA request for applications for a State Implementation Grant for Enhancing the System of Services for CYSHCN through System Integration. Although that opportunity was approved but not funded in the first year, funding was granted in the second year. Aims set forth by HRSA in three domains, cross-system care coordination, integration, and shared resource, are being addressed in collaboration with SPAN, NJ-AAP, and a subset of the SCHS CMUS.

In 2014, ongoing improvements to the Case Management Referral System (CMRS) allowed new and different opportunities to track NPM 11 and 12. Rather than definitive identifiers for these Performance Measures, "proxies" were identified and used for this year's reporting. SCHS CMUs served 20,465 children in FFY 2015.

Annual Report - NPM #12

Efforts to improve documentation of transition to adulthood activities performed by SCHS CMs and documented in the electronic Case Management Referral System (CMRS) were implemented. State staffs provided technical assistance and guidance via site visits, desktop audits, and conference calls to improve the data collected and reported on transition to adulthood activities and client outcomes.

The adolescent subset of CYSHCN served through Title V is observed to be significant. In SFY 2015, approximately 14% of CYSHCN served across the SCHS CMUs were aged 14-19 years of age. The percentage of youth age 14-19 years served by the SPSP agencies was greater, comprising nearly 26% of those served by the Tertiary Centers, and 15% by the CEC/FAS Centers. The Cleft Lip/Palate Craniofacial Centers reported 9% CYSHCN served among that same age group. Although these distributions remain fairly consistent with previous years' reporting, transition planning and implementation remained a priority for these youth, their families, NJ Title V, and providers.

Documentation of transition planning was largely noted by SCHS CMUs to occur on or about age 14. A discussion with parents/youth about transition planning, and the distribution of transition packets were noted. An anecdotal observation by the SCHS CMs noted that families reported that they preferred to receive materials incrementally rather than one very large packet filled with resources. That incremental method provided them with the opportunity to focus on one or a few transition needs at a time, such as primary care provider; access to Supplemental Security Income and/or health insurance including Medicaid, Medicaid expansion and/or private insurance or the Marketplace; education/job training supports; statewide systems of care including the Department of Human Services' Division of

Developmental Disabilities and/or the Department of Children and Family's Children's System of Care Initiative, and others. Follow-up monitoring and discussion supported family's ability to digest the material, and critically think about their needs over time.

The Specialized Pediatric Services (SPS) providers conducted evaluations and developed service plans with adolescent CYSCHN and their families. In addition, SPS providers reported providing youth with transition to adulthood resources regarding genetics, family medicine, adult providers, support groups and other medical and social related needs. The linkage of CYSHCN to multidisciplinary team members including social work and other community-based systems such as SCHS CM, SPAN, and disability-specific organizations including the Arc, Tourette's Association, and Parents' Caucus was also a strategy implemented by the SPSP agencies.

Through an agreement with SPAN, the Family WRAP (Wisdom, Resources and Parent to Parent) project provides information, resources and one-to-one family support that are directly helpful to clients. Likewise, the close working relationship with the SCHS CMUs and the SPAN Resource Parents and Parent to Parent family support offers some opportunities for cross-training on community-based resources for transition.

Linkages developed through previous ISG grants had facilitated the distribution of materials developed by SPAN, NJ AAP, NJDOH, and other community partners engaged in the COCC to medical practices. Community-based partners continued to identify resources and linkages to support transition to adulthood for CYSHCN. Likewise, training was provided to Title V providers on work incentives for persons who receive SSI or SSDI benefits, and NJ DHS' Managed Long Term Services and Supports program.

A major systems change in the redistribution of services for children and adolescents under age 16 with developmental disabilities was implemented. Access to care for those children and adolescents has been reassigned to the DCF, and they are also charged with collaboration with the Department of Education (DOE) and DHS's Division of Developmental Disabilities (DDD) to facilitate transition to adulthood services. At age 18 or high school graduation, youth/young adults' services are the responsibility of the DHS's DDD. Training on this systems change, as well as continued training on DHS' DDD and DCF's Children's System of Care Initiative affecting adolescents with developmental disabilities, is occurring with regularity among the SCHS CMUs. Collaboration with intergovernmental and community partners including DDD, DCF, NJ Council on Developmental Disabilities, Boggs Center, SPAN, the Arc, Traumatic Brain Injury Association and families is critical to appropriate access to services and supports. Identification and monitoring of transition to adulthood needs for CYSHCN and their families served through SCHS CMUs statewide is in process as well. County-specific transition packets including resources related to education, post-secondary education, vocational rehabilitation, housing, guardianship, SSI, insurance, and Medicaid/NJ FamilyCare are shared with families and linkage with community-based supports is provided. State staffs monitor the SCHS CMU's efforts to inreach and outreach to CYSHCN regarding transition, and documentation of goals related to transition on adolescents' individualized service plans.

Aligned with the Title V CYSHCN programs and funded by Part D of the Ryan White Care Act, the NJ Statewide Family Centered HIV Care Network remains a leading force in providing care to women, infants, children, youth (WICY) and families infected and affected by HIV disease in the State. Consequently, there is ongoing collaboration across systems within the Division of Family Health Services' Maternal Child Health and CYSHCN's programs, and the Ryan White Part D program to support WICY needs in the community. NJ ranks third in the nation for pediatric cases. Of youth 13-24 years, 1,118 were living with HIV/AIDS in 2014. Through diligent efforts to treat and educate HIV-infected pregnant women, the perinatal transmission rate in NJ remains very low. Intensive case management, coupled with appropriate antiretroviral therapy, enables children with HIV to survive into and successfully transition into adulthood.

However, transition to an adult program for CYSCHN is a critical decision and one that must be planned appropriately to ensure the youth remains in care. In 2013, the Title V CYSHCN program critically reviewed transition to adulthood across its community-based services, and presented a poster depicting

NJ's experience at the annual AMCHP conference. Although Title V will continue to assess youth's progress toward transition and linkage with community-based supports, the SCHS CM and SPSP programs are exploring the development of standardized needs assessment and quality indicators to better measure NJ CYSHCN's experiences.

II.F.1.e. CSHCN

The population domain of CSHCN includes NPM #11 and #12 which were covered in the previous Adolescent / Young Adult Health domain and SPMs 3, 4 and 5 which impact NOMs 13, 15, 16, 17, 18, 19, 20, 21 and 22.

Plan for the Application Year

State Performance Measure 3: Percentage of newborns who are discharged from NJ hospitals, reside in NJ, did not pass their newborn hearing screening and who have outpatient audiological follow-up documented.

An important SPM in the domain of CSHCN is SPM #3 (Percentage of newborns who are discharged from NJ hospitals, reside in NJ, did not pass their newborn hearing screening and who have outpatient audiological follow-up documented) which was selected during the last Five-Year Needs Assessment.

The New Jersey EHDI Quality Improvement Stakeholders Committee and subcommittees are continuing to meet and to identify tests of change for improvement of screening, diagnostic testing and early intervention enrollment. EHDI staff will work with two or three hospitals that have lower-than-average follow-up rates to develop PDSA model quality improvement projects to identify and implement changes at their facilities.

The EHDI program will continue to send hospital-level surveillance data to each hospital with maternity services. A report with their overall statistics is sent semiannually, and in intervening quarters, hospital contacts receive a list of children who are still in need of follow-up after missed or referred inpatient hearing screening. The program will use a PDSA quality improvement process to determine if a monthly notification to hospitals of children in need of a follow-up improves outcomes.

The program will continue annual distribution of audiology facility reports to highlight timeliness of follow-up and identify children with incomplete follow-up testing.

The EHDI program plans to increase efforts to work with the medical home to ensure children are receiving follow-up after referred hearing screening or inconclusive follow-up testing. A new extract was made available in the New Jersey Immunization Information System (NIIIS) to allow the EHDI program to identify the name, address and fax number of the medical home provider that has most recently provided immunization data for a child and will use this to send fax-back forms to provider offices to remind providers to refer children for additional follow-up.

The program will continue the grant-supported activities including case management outreach to families in need of hearing follow-up and support by the EI hearing consultants, pending continued availability of grant funds.

EHDI staff will provide educational presentations to hospital staff, pediatricians, audiologists, otolaryngologists, special child health service case managers, Early Intervention Service coordinators, and other health care professionals, focusing on the need to decrease rates of children lost to follow-up. The EHDI program frequently uses webinars to make educational outreach efforts more accessible to the target audiences, decrease staff travel time, and improve efficiency while decreasing costs.

Plan for the Application Year

State Performance Measure 4: Percent of live children registered with the Birth Defects and Autism Reporting System (BDARS) who have been referred to NJ's Special Child Health Services Case Management Unit who are receiving services.

SPM #4 was chosen to improve the timeliness and effectiveness of using the Birth Defects and Autism Reporting System (BDARS), which has been an invaluable tool for surveillance, needs assessment, service planning, research, and to link families to services. NJ has the oldest requirement in the nation for the reporting of birth defects, starting in 1928, and since then, linking registered children to health services. Since 1985, NJ has maintained a population-based registry of children with all defects. Starting in 2003, the Early Identification and Monitoring (EIM) Program received a CDC cooperative agreement for the implementation of a web-based data reporting and tracking system. In 2007, NJ passed legislation mandating the reporting of Autism. Subsequently, with the adoption of legislative rules in 2009, the Registry added the Autism Spectrum Disorders (ASD) as reportable diagnoses, was renamed the Birth Defects & Autism Reporting System (BDARS), expanded the mandatory reporting age for children diagnosed with birth defects up to age 6, and added severe hyperbilirubinemia as a reportable condition. The system refers all living children and their families to our SCHS Case Management Units via the BDARS direct link to the Case Management Referral System (CMRS).

In 2016, CDC funding continues to assist the Program in making improvements to the Birth Defects Surveillance System. The BCSR will continue making improvements to the Birth Defects & Autism Reporting System (BDARS), CMRS, Pulse Oximetry, and Exceptional Events Module to improve their ease of operation and efficiency.

BDR staff will continue to provide training, on an as-needed basis, to birthing facilities, autism centers, Case Management Units, and other agencies in the use of the electronic BDARS and its modules. Staff will continue to monitor the use of the electronic BDARS, especially the Case Management Module, and will assist reporting agencies and CM Units with concerns. In addition, BDR staff will continue to review the quality of the data in the BDARS and its modules.

Site visits will continue to be conducted in each of NJ's birthing hospitals and County Case Management Units to ensure proper usage of the BDARS and its Case Management Module as needed. BDR and FCCS staff also will be reviewing the CMUs' performance in linking referred families to services. Units having the lowest levels of linking families to services will receive remedial assistance from staff of the BDARS and FCCS.

BDR staff will continue to work with the agencies to ensure complete and appropriate referral to services. BDR staff also will be working with non-traditional reporting sources, e.g., FQHCs, and facilities from bordering states to register children with birth defects and/or special health care needs. Building upon information visits conducted in FFY 2013, Federally Qualified Health Centers will be encouraged to report children diagnosed in their facilities.

Surveillance activities will expand due to the increase in readily available electronic data. These will include identifying any relationships between diagnoses, geographic and temporal patterns, and other descriptive statistics.

Plan for the Application Year

State Performance Measure 5: Average age of initial diagnosis for children reported to the NJ Birth Defects & Autism Reporting System (BDARS) with an Autism Spectrum Disorder.

	2009	2010	2011	2012	2013	2014
Annual Indicator SPM #5	4.4 years	4.2	4.6	4.7	4.8	5.3

Notes - Data has not yet been subject to quality assurance reviews.

SPM #5 was chosen to measure the timeliness of diagnosing autism in children. Early diagnosis is important for initiation of services, as children who receive services at an early age have better functional outcomes. Based on the most recent data available from the BDARS, the average age of initial diagnosis of an autism spectrum disorder of children reported to the NJ Autism Registry is 5.3 years old. Although there is no timeline for diagnosing autism, the Registry encourages all reporting agents to quickly report children diagnosed with the autism spectrum disorders so that families can be linked to SCHS Case Management

While the causes of autism are not known, receiving intensive services early in a child's life can improve development in speech, cognitive, and motor skills. Appropriate diagnosis at an early age is an important precursor to ensuring that families gain access to early and intensive intervention. In NJ, the average age of initial diagnosis of an autism spectrum disorder of children reported to the Registry increased from 4.8 in 2013 to 5.3 2014. We believe this is due to Registry reporters being more behavioral health units who typically treat children with Asperger's Disorder. The average age of a child with Asperger's is considerably higher than a child with either autistic disorder and/or pervasive developmental disorder-not otherwise specified, 8.3 years old, versus 4.6, and 4.9 respectively. Two important activities in the upcoming years that will change the reporting of age of first diagnosis in the Registry is the rewriting of the Autism Registry rules and the redesigning of the Birth Defects Reporting System (BDARS) that will capture the age of the child when he or she was first diagnosed as opposed to the date of first diagnosis. The new rules will be tied to the new Diagnostic and Statistical Manual (DSM) 5 criteria for autism spectrum disorders and eliminate the reporting of the specific disorders of autistic disorder, Asperger's disorder, and pervasive developmental disorder –not otherwise specified (PDD-NOS).

In order for this performance measure to be accurately determined, patients who are under the age of 22 with autism in NJ need to be reported to the Autism Registry by licensed health care providers who have either diagnosed them or are providing follow-up care and have the full information regarding the child's date of first diagnosis. BDARS staff has have conducted outreach to educate and inform physicians and health facilities about the Registry, how they can register children with autism living in NJ, and the rules regarding the Registry. Registry staff have visited and trained staff from medical centers specializing in child development, developmental evaluations, and behavioral health. Additionally, they have trained staff from many private pediatric practices that follow older children with autism through annual well visits. Registry staff have also trained several psychiatric/behavioral departments located within hospitals including units within Newark Beth Israel Medical Center, University Medical Center of Princeton at Plainsboro, St. Clare's Medical Center, and Meridian Health System's which includes Jersey Shore Medical Center and Riverview Medical Center. Staff from the Registry presented information concerning the Autism Registry to state and county case managers as part of training on the case management electronic component to the BDARS and they continue to retrain new staff within health facilities as needed. Staff has also created materials for both providers and families about autism and these materials have been translated into multiple languages including Spanish, Korean, Polish, Hindi, and Arabic. There is also information about the Autism Registry on the DOH website and staff continue to make conference presentations and exhibits.

NJDOH has also addressed this performance measure by working with the NJ Chapter of the American Academy of Pediatrics and the Elizabeth M. Boggs Center on Developmental Disabilities, NJ's University Centers for Excellence in Developmental Disabilities (UCEDD), in reaching out to various health care providers and distributing information and trainings on the Learn the Signs, Act Early campaign that educates providers on childhood development, including early warning signs of autism and other developmental disorders, as well as to encourage developmental screenings and intervention. In addition, the Governor's Council on Medical Research and Treatment of Autism's Clinical Enhancement Center has funded additional clinical centers in their pursuit to create a NJ Autism Center of Excellence (NJACE).

NJDOH will continue to focus on the importance of early identification of autism. Registry outreach efforts will continue with harder-to-reach providers such as office-based pediatric offices and those not affiliated with a major hospital through mailings and collaboration with other state Departments such as the Department of Education. Providers with less timely reporting to the Registry will continue to be

contacted and reminded of the mandate to report and of the importance of the linkage to SCHS Case Management Units. The case management component of the BDARS will allow for an electronic assessment of referral rates. Registry staff will be able to use these reports to monitor timeliness as well as numbers.

The NJDOH is committed to continuing efforts to reduce the age of the first diagnosis to of autism. The Governor's Council for Medical Research and Treatment of Autism will continue to fund new grantees in their efforts of early identification of autism in children. Additionally, Early Intervention Systems will continue their efforts with such providers as speech pathologists, occupational therapists and so forth who will act as a basis for early referral of children at risk for autism.

Annual Report (Last Year's Accomplishments)
State Performance Measure 3:

Provisional data indicates that for 2013, 82.1% of infants received follow-up after referring on inpatient screening. Since follow-up exams are still occurring on children born at the end of 2013, we expect that the rate will increase when final data is available. We anticipate the final rate will be level with prior years and will exceed the 83% target.

Table SPM #3: Percentage of newborns who are discharged from NJ hospitals, reside in NJ, did not pass their newborn hearing screening and who have outpatient audiological follow-up documented.

	2008	2009	2010	2011	2012	2013	2014	2015
Annual SPM#3 Indicator	74.2%	78.9%	86.1%	86.0%	86.4%	88.2%	85.8%	80.8%*
Numerator	2246	2364	2444	2451	2131	1945	1821	1714*
Denominator	3026	2997	2837	2850	2467	2205	2122	2120*

*Note – Data for 2015 is incomplete, follow-up reports are still being received for these children and the final rate is expected to exceed this rate.

The Early Hearing Detection and Intervention (EHDI) program is responsible for assuring newborn hearing screening goals are met, including assuring audiological follow-up for children that did not pass initial screening. The following activities were completed in 2015 to achieve program goals:

- The Office of Vital Statistics and Registry (OVSR) began implementation of a new Electronic Birth Registration system, known as the Vital Information Platform (VIP) with six pilot test hospitals using the system starting in July 2014. The other 45 hospital converted to the VIP system between April and June 2015. The EHDI program worked with OVSR to ensure the continued capture of inpatient hearing screening results and risk indicators via the new system. Reports routinely generated by the EHDI program, such as hospital-specific statistics and audiology facility reports were reprogrammed to adjust to the changed data elements captured in the new system.

- Members of the multidisciplinary EHDI Quality Improvement Stakeholder Committee continued regular conference call meetings throughout 2015. This committee has developed aim statements and four subcommittees were established (medical home, audiology, hospital refer follow-up, and early intervention) which are each meeting and working to develop and implement small tests of change. The Plan-Do-Study-Act (PDSA) model of quality improvement is being utilized for these activities.

- Completed the annual update to the NJ Pediatric Hearing Health Care Directory, a listing of audiologists, hearing aid dispensers, and otolaryngologists who provide services to young children. The Directory is available on the internet at www.hearinghelp4kids.nj.gov.

- Trained 10 new users on the EHDI reporting module in the NJ Immunization Information System (NJIIS) which is used by audiologists and other practitioners who are conducting hearing follow-up to report outpatient exams. The EHDI program receives approximately 89% of reports entered by providers through this Web-based application and the rest are sent to the program on paper forms.

- Continued use of HRSA EHDI grant funding for county-based special child health services case management staff to conduct follow-up phone calls to parents and physicians of children in need of hearing follow-up. During 2015 the case managers contacted 929 families.

- Continued use of HRSA EHDI grant funding for one of the Early Intervention (EI) program's Regional Early Intervention Collaborative's (REIC) to provide two part-time consultants who specialize in working with children with hearing loss. They have an initial phone conversation with parents of children who have recently been diagnosed with hearing loss to review EI services and discuss communication options for children with hearing loss. The consultants participate in the initial early intervention family meetings via remote access, using laptops with web-cameras. The consultants served a total of 162 families during the year.

- Continued quarterly distribution to hospitals of report detailing children still in need of additional audiological follow-up after not passing inpatient hearing screening. Semi-annual reports also include statistics comparing the hospital to statewide averages.

- Continued annual distribution of a report to provide audiology facilities with feedback on the timeliness of follow-up for children seen at their facility after not passing inpatient hearing screening. The report also includes statistics on the timeliness and completeness of the documentation of their results.

- Presented information in multiple formats including conference calls, webinars, and in-person presentations on a variety of EHDI-related subjects to varied audiences which included parent support staff, audiologists, and hospital birth certificate clerks. In 2015 in-person presentations included a presentation to the New Jersey Department of Human Services Division of the Deaf and Hard of Hearing Advisory Committee in April 2015 and a presentation to New York Mid-Atlantic Consortium for Genetic and Newborn Screening Services Medical Home Learning Session in May 2015. Three webinars were held for hospital EHDI contacts focusing on the PDSA process and examples of successful quality improvement efforts. These were held in March, April and June 2015. Three webinars were held for the EHDI audiology community, in May about Department of Education services, in June about the EI EHDI hearing consultants and in September providing results on a survey of pediatric audiology practices.

b. Annual Report (Last Year's Accomplishments)

State Performance Measure 4:

NJ has been very successful in linking children registered with the Birth Defects Registry (BDR) (also known as the Special Child Health Services Registry) with services offered through our county-based Special Child Health Services Case Management Units (CMUs). However, the system did not track children and families to determine if and what services were offered to any of the registered children. To address this weakness, added in 2012, the Case Management Referral Systems (CMRS) is used by the CMUs to track and monitor services provided to the children and their families. It electronically notifies a CMU when a child living within their county has been registered. Also included in CMRS is the ability to create and modify an Individual Service Plan (ISP), track services, create a record of each contact with the child and child's family, create standardized quarterly reports and other reports, and register previously unregistered children.

State Performance Measure 4: Percent of live children registered with the Birth Defects and Autism Reporting System (BDARS) who have been referred to NJ's Special Child Health Services Case Management Unit who are receiving services.

	2010	2011	2012	2013	2014	2015
Annual Indicator SPM #4			36	50	84.7	88.9
Numerator			1747	3508	11,089	13,696
Denominator			4875	7047	13,096	15,404

Note: Above 2012 data was based upon the time period of February – September 2012 due to implementing the Case Management Module in January 2012. The numerator reflects all children whose records contain an ISP objective begin date or perform date within the FFY 2013 (2674) or were referred to the Early Intervention Program (432) or whose records indicated that the child's goals were achieved, but there was no record of any services (402). The denominator reflects the number of children referred from the BDARS (7047). There also were 471 children whose case status were active, but had no record of any services. There were 1,452 children whose families did not respond to any contact attempt by the Case Management Unit.

In 2014, definitions and inclusion criteria were expanded. In FFY 2014, 11,089 children received Special Child Health Case Management Services who had been registered by the BDARS, 857 of which were originally in case management and later registered with the BDARS. The numerator reflects all children whose record has any of the five following criteria for services:
1. Case closed within FFY 2014 with a reason of "goals achieved"
2. Child referred to Early Intervention within FFY 2014
3. Individualized Services documented with a begin and/or end date within FFY 2014
4. Individualized Service Objectives documented with a perform date within FFY 2014
5. Case Management Actions (excluding any letter correspondence that is part of an initial letter series) documented with a date performed within FFY 2014
These children must have received any of these services within FFY 2014 and been registered with the BDARS (registration date not restricted to federal fiscal year 2014).

The denominator represents the number of children served by SCHS Case Management in federal fiscal year 2014 who had been registered with the BDARS regardless of registration date (i.e., the numerator) plus any additional children who were registered and released to case management within federal fiscal year 2014 but did not receive services as currently defined (n=2,007). These expanded definitions and inclusion criteria were retained for FFY 2015 reporting.

CMRS allows CMUs to receive registrations in real time, enables faster family contact, and more rapidly assists a registered child in gaining access to appropriate health and education services.

In 2013, CDC continued to fund the BDARS through a cooperative agreement for improvements in the Birth Defects Surveillance system. Rutgers, Bloustein Center for Survey Research (BCSR) continued the deployment of CMRS for the BDARS. During and after deployment, the BCSR continued to work with staff from both the EIM Program and the SCHS county-based CMUs to identify and correct issues in the case tracking and management component of the BDARS. In 2014, within the CMRS component of BDARS, the BCSR created and implemented an Exceptional Event module in collaboration with BDAR and Family Centered Care Services (FCCS) staff. The Exceptional Event module was originally intended to track families affected by Super Storm Sandy using Social Services Block Grant (SSBG) funds. However, team collaboration suggested the expansion and adaptability of this module to track other natural disasters, interpersonal family crises, and other 'exceptional events' that may impact the needs of children with special health care needs and their family.

The Pulse Oximetry Module continues to collect information on children who failed their newborn pulse oximetry screening test, which is used to identify children at risk for critical congenital heart defects (CCHD), which may not be apparent at birth. New Jersey is the first state in the nation to integrate the

CCHD screening with their birth defects registry. Each month EIM Program staff review information from the Pulse Oximetry Module to determine the final diagnosis of a child who failed the screening test. This review involves determining whether the child has been diagnosed with a CCHD by reviewing BDARS registrations and contacting the hospital that performed the screening test.

BDR staff continued to provide training to birthing facilities, autism centers, and CMUs in the use of the electronic BDARS. They also continued to assist the units as they transition from the paper-based system to the electronic system.

In 2014, the SCHS Registry:
• Processed registrations for over 9,200 children with birth defects and other special health needs,
• Referred nearly 7,400 families to the SCHS CMUs, and
• Received over 2,400 new autism-related registrations, excluding anonymous registrations.

BDR staff continues to collaborate with staff from the Family Centered Care Services Program (FCCS) and BCSR to identify and correct issues related to the BDARS and the CMRS to improve its ease of use and efficiency. In 2015, CDC continues to fund the Program through a cooperative agreement for improvements in the Birth Defects Surveillance System. The BCRS will continue making improvements to the BDARS, the Case Management and Pulse Oximetry Modules, and the development of the Exceptional Events Module. The BDR staff will continue to work with the hospitals and other agencies to ensure complete reporting, especially with the birthing hospitals to ensure all children who failed their pulse oximetry screening test are reported through the BDARS.

Site visits will be conducted in each of NJ's birthing hospitals to audit their reporting through the BDARS. In addition, BDR staff will be reviewing the CMUs' performance in linking referred families to services. Facilities having the lowest levels of appropriate reporting, based upon results of the audits, will receive remedial assistance from staff of the BDR and FCCS. The BDR staff will continue to identify non-traditional reporting sources, e.g., FQHC, as a means to ensure all families with special health care needs children will be identified and referred to the appropriate CMU for services.

FCCS staff revised annual site visit audits to include protocol-based review of electronic records in CMRS. In these electronic record reviews, staff assessed key functions and expectations of the CMUs and evaluated Individualized Service Plans to assess linkage to services. FCCS staff is also beginning to review electronic documentation of the six key performance indicators (e.g., medical home, transition to adulthood), with an expectation of refining how this information is collected within CMRS. On-site annual audits continue to programmatically evaluate CMUs to ensure consistency of services provided within and between CMUs.

b. Annual Report (Last Year's Accomplishments)
State Performance Measure 5:

The New Jersey Autism Registry is the largest mandated autism registry in the country with 20,125 children registered as of November 24, 2015. We are the only registry that includes children up to the age of 22 and refers them to case management services. We serve as a model registry and continue to provide technical assistance with other states considering a Registry, such as Massachusetts. In FY 2014, over 1,800 children were newly reported to the BDARS including all children with a diagnosis of autistic disorder, Asperger's syndrome, or pervasive developmental disorder and who had information about the date of first diagnosis. Staff has stressed the importance of quickly reporting children diagnosed as having autism by continuing to provide outreach about the Autism Registry through conference presentations and focused meetings. Staff participated in several exhibits including the Annual School Health Conference sponsored by the NJ Chapter of the AAP and have presented to a number of private pediatric offices throughout NJ. Staff continues to send out mailings on a periodic basis to newly identified providers and have recently deployed a new Autism Registry webpage (http://www.state.nj.us/health/fhs/sch/autism_registry.shtml) which will include information for parents, providers, and researchers.

Providers with untimely reporting were contacted and reminded of the mandate to report and of the importance of the linkage to SCHS CMUs. The electronic reporting component of the BDARS facilitated timelier reporting by facilities and since the BDARS added the SCHS CMU component, referral of these children to services is significantly faster. A specific target for this current year was conducting our first annual audit of autism reporting facilities in conjunction with the Birth Defects quality assurance audits.

II.F.1.f. Cross-cutting or Life Course

This section concerning the domain of Life Course includes the SPN #8 Improving Integration of Information Systems and SPN #8 Smoking Prevention and the NPM # 13 Oral Health and #14 Household Smoking. SPN #8 was added as a SPN recognizing the adverse impact of smoking on all population domains and many NPMs and NOMs.

Plan for the Application Year - NPM #13:
A) Percent of women who had a dental visit during pregnancy and
B) Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Oral health is an important part of general health. The second selected NPM in the domain of Child Health is NPM #13A (Percent of women who had a dental visit during pregnancy) and #13B (Percent of children, ages 1 through 17, who had a preventive dental visit in the past year). Access to oral health care, good oral hygiene, and adequate nutrition are essential components of oral health that help to ensure children, adolescents, and adults achieve and maintain oral health throughout the lifespan. People with limited access to preventive oral health services are at greater risk for oral diseases.

Oral health care remains the greatest unmet health need for children. Insufficient access to oral health care and effective preventive services affects children's health, education, and ability to learn. Having the first dental visit by age 1 as recommended by the American Academy of Pediatrics, teaches children that oral health is important. Children who receive oral health care early in life are more likely to have a positive attitude about oral health professionals and dental exams. Pregnant women who receive oral health care are more likely to take their children for regular dental check-ups.

State Title V Maternal Child Health programs have long recognized the importance of improving the availability and quality of services to improve oral health for children and pregnant women. States monitor and guide service delivery to assure that all children have access to preventive oral health services. Strategies for promoting good oral health include providing preventive interventions such as age appropriate oral health education, promotion the application of dental sealants, use of fluoride, and increasing the capacity of State oral health programs to provide preventive services, evaluating and improving methods of monitoring oral disease and increasing the number of community health centers with an oral health component.

Table NPM #13

	2007	2008	2009	2010	2011-2012	2014
Percent of women who had a dental visit during pregnancy	N/A				N/A	
Percent of children, ages 1 through 17, who had a preventive dental visit in the past year	78.7				79.9	

Notes - Source – National Survey of Children's Health (NSCH)

Utilizing an evidence-based strategy approach in future years, the COHP plans to continue the implementation of the following program initiatives while also enhancing efforts that reach school-age

children and pregnant women through oral health and hygiene education efforts supplemented with oral health personal care resources.

COHP has selected the following ESM #13 Preventive and any dental services for children enrolled in Medicaid or CHIP. The ESM was selected since all oral health education activities conducted in the school and community setting serve to enhance the oral health status of school age children. The COHP provides age-appropriate oral health and hygiene education, healthy food choice selection, smoke, smoke-less and spit tobacco cessation, and oral injury prevention education along with mouth-guard distribution in areas of high need, high risk, where the water is not optimally fluoridated. In addition, numerous special initiatives take place including, "Sugar-less Day to Prevent Tooth Decay, "Projects: BRUSH, PEDs and REACH, and Project SMILE which not only educate students about the importance of preventive oral health practices but also serves to increase family and community awareness due to family and community engagement. In addition, every 2 years, the New Jersey Department of Health updates the Dental Clinic Directory, "Dial a Smile" that serves as a public resource to assist in identifying providers of clinical dental services. Assisting students and families to establish a dental home helps them to receive regular dental check-ups and serves to assist in the elimination of costly emergency room dental visits. The "Be a Smart Mouth" oral health Home Visiting Initiative targets first time families and engages the family in oral health and hygiene dialogue. Through the "Be a Smart Mouth" Initiative, NJ home visiting staff are trained to assist families to establish a dental home.

NJ has developed and implemented the "Be a Smart Mouth" oral health component for home visiting programs that was implemented in 2014. Through a Statewide effort, over 4,000 families participating in the MIECHV Program were reached and provided oral health education and personal care resources. Families were assisted in establishing a dental home and encouraged to have regular dental exams. In 2015, the COHP continued to develop and implement cutting edge programs such as the continuation of the "Be a Smart Mouth: Home Visiting and Oral Health Perfect Together! Initiative. The integration of oral health into the home visiting program allows trained staff to provide oral health and hygiene instruction and healthy food choices education to first time families while assisting them to establish a dental home to reduce hospital emergency room dental visits that reduce health care costs. As a result of the 2015 oral health trainings, over 2,600 families were reached. Program efforts will continue for home visiting staff from the 3 NJ Home Visiting model programs emphasizing the importance of oral health preventive measures, healthy food choices, and regular dental exams. Given the success of "Be a Smart Mouth," this NJ Program has been shared with the Association of State and Territorial Dental Directors as a Best Practice Approach and with the National Nursing Workgroup on Oral Health. In addition, "Be a Smart Mouth" training materials were shared with our federal partners and reviewers at the NJ Block Grant Meeting in New York, August, 2015. In response to a request from the National Maternal Child Health Resource Center, seeking information pertaining to home visiting programs with an oral health component, NJ provided an over view of the "Be a Smart Mouth" oral health training program for review and potential replication on a national level. In addition, state specific consultation occurred with other states including the Bureau 0of Oral Health and Dental Services in Delaware to assist in the development of an oral health component for home visiting programs. Program promotion efforts will continue to emphasize "Be a Smart Mouth" as a cost-effective model for replication on a national level with the goal of increasing the number of first-time families who have a dental home and receive a preventive dental visit.

As an upcoming activity through collaborative efforts, the COHP plans to work with staff from the Department of Children and Families and home visiting staff from the three NJ MIEC Home Visiting Programs to determine the following information:

1. Do you have a dentist?
2. Did you have a dental check-up in the last year? (pregnant woman)
3. Did your child have a dental check-up in the last year?

Home visiting staff attending the 2015 training programs reported regularly using the NJ Dental Clinic Directory, "Dial a Smile" and the "NJ Dental Smiles Directory." Staff report "parents are willing to get their kids in for dental visits"

Project REACH, (Reducing Early Childhood Caries Through Access to Care and Education) is a multidisciplinary train-the-trainer initiative that provides oral health education and resources to educate obstetrical staff about the importance of good oral health with the overarching goal of reducing early childhood caries through dissemination of oral health education and personal care resources for pregnant women and their children and referring them for dental services along with establishing a dental home. Approximately 2,200 multi-disciplinary providers were trained during 2015.

Project PEDs (Pediatricians Preventing Early Dental Disease) is a multidisciplinary train-the-trainer initiative that provides oral health education and resources to educate pediatricians about the importance of oral health and assist them to incorporate preventive oral health education in the well child visit. Through dissemination of oral health education and personal care resources along with dental care referrals and assistance in establishing a dental home, clients will be encouraged to seek preventive dental care visits. Over 3,100 multi-disciplinary providers participated in Project PEDs trainings throughout the State.

The NJ Dental Clinic Directory, “Dial a Smile” is a public source of information on dental clinic services in NJ. The Directory has a Statewide distribution to school nurses, hospital emergency room directors and nurse managers, summer camps directors, athletic directors and home visitors from the three NJ MIECHV Programs. Staff use the Directory to refer individuals for dental care services and assist them to establish a dental home. Use of the Directory helps to reduce costly hospital emergency room care for non-traumatic dental services and increases the use of the Statewide network of Federally Qualified Health Centers. The Program submitted a “Best Practice Report” to the Association of State and Territorial Dental Directors on state success of the Directory to assist consumers to establish a dental home. In addition, a survey was developed and mailed to all FQHC administrators, health department directors and dental and hygiene schools to update information on dental clinical services provided. The updates will be included in the 2016 edition of the NJ Dental Clinic Directory, “Dial a Smile.”

In aligning with the national trend to incorporate an oral health education component into nursing curriculum, the Director, Children’s Oral Health Program explored options to include an oral health component into the maternity, pediatric and community health clinical experiences at Schools of Nursing in New Jersey. The College of New Jersey, School of Nursing, Health and Exercise Science has agreed to partner with the Children’s Oral Health Program to implement an oral health and hygiene and oral health literary initiative for the community health nursing clinical component for senior level nursing students. This special initiative, “Bedtime Bytes” was funded by the Dental Trade Alliance with additional support from the NJ Department of Health. The Director, COHP will be reaching out to Deans of other Schools of Nursing to implement an oral health component in the community health clinical experience.

National Performance Measure 14:

A) Percent of women who smoke during pregnancy and
B) Percent of children who live in households where someone smokes

Adverse effects of parental smoking on children have been a clinical and public health concern for decades and were documented in the 1986 U.S. Surgeon General’s Report. Unfortunately, millions (more than 60%) of children are exposed to secondhand smoke in their homes. These children have an increased frequency of ear infections; acute respiratory illnesses and related hospital admissions during infancy; severe asthma and asthma-related problems; lower respiratory tract infections leading to 7,500 to 15,000 hospitalizations annually in children under 18 months; and sudden infant death syndrome (SIDS).

As a result of the many health consequences, the health costs from smoking in pregnancy are significant. The excess costs for prenatal care and complicated births among pregnant women who smoke exceed $4 billion a year. It has been estimated that a 1% drop in rates of smoking among pregnant women could result in a savings to the US of $21 million in direct medical costs in the first year. Another $572 million in direct costs could be saved if the rates continued to drop by 1% a year over seven years. Secondhand smoke also has significant health effects on an infant. Pregnant women exposed to second handsmoke have a 20% increased risk of having an infant born with low birth weight, and secondhand smoke

exposure also increases the risk for infections in the infant, and even death from SIDS. Children living with smokers are also more likely to get asthma attacks, ear infections, and serious respiratory illnesses like pneumonia and bronchitis due to secondhand smoke. The cost to care for childhood illnesses resulting from exposure to secondhand smoke is estimated at $8 billion a year. In addition to the effects during the perinatal period, health consequences for older children and adults (whether from directly smoking or from a secondhand exposure) are well documented in the literature and include respiratory infections and disease, cancer, and death.

Tables NPM 14A & B:

A) Percent of women who smoke during pregnancy

	2003	2004	2005	2006	2007	2008	2009	2010	2011
14 A. Percent of women who smoke during pregnancy	16.6	16.7	16.2	15.0	14.1	15.8	19.3	18.1	17.1

Notes - Data is from the NJ PRAMS Survey and the CDC Ponder System.
See NJ PRAMS Brief on Smoking and Pregnancy in NJ at
http://www.state.nj.us/health/fhs/documents/brief_smoking_prevalence.pdf

B) Percent of children who live in households where someone smokes

Annual Objective and Performance Data	2003	2007	2011-2012
14B. Percent of children who live in households where someone smokes	28.7	19.7	20.3

Data Source: National Survey of Children's Health (NSCH)

Plan for the Application Year (Plan for the Coming Year)

National Performance Measure 14:

Plans for the upcoming year to address NPM #14 include:
Promoting Mom's Quit Connection (MQC) to expand reach to pregnant and parenting mothers in NJ;

- Train prenatal health care providers to screen and refer smoking adolescent and adult patients (with a specific focus on pregnant/postpartum mothers).
- Train statewide prenatal providers to generate an automatic electronic referral for pregnant smokers identified during the Perinatal Risk Assessment (PRA) process. The Southern New Jersey Perinatal Cooperative is currently piloting PRA electronic referral to MQC in four pilot sites in the South. PRA is being used more and more frequently in the state and an automatic referral would increase the reach of MQC across NJ.
- Conduct an extensive public awareness campaign re availability of MQC for pregnant women who smoke. Use no-cost and low-cost television and radio advertisements, many of which are available from the Centers for Disease Control and Prevention.

Increasing Capacity for Direct Service in NJ;

- Continue to expand MQC's existing services to enable face-to-face counseling in the Northern and Central regions of the state, handle increased volume of calls and requests for face-to-face counseling resulting from outreach activities, and expand activities into the postpartum period to decrease the likelihood of relapse.
- While MQC does not currently turn away postpartum women, because of limited funding, they do not actively outreach to or offer programming specifically for postpartum women. Because of the high relapse rate in postpartum women, it is essential to expand programming to address this population's needs.

Preventing relapse after delivery;

- Develop Pregnant Smoker to Stay Quit Mom interactive online app and social networking site to connect women with cessation services, provide mechanism for registering/intake survey, offer stay quit support (e.g, online chat groups for parenting moms), and provide targeted and general cessation information.
- Develop a personalized quit plan using the newly developed online app and send personalized Text to Quit messages to pregnant women and new mothers.

Preventing young people from starting to use tobacco is the key to reducing the death and disease caused by tobacco use. Adolescent smoking and smokeless tobacco use are the first steps in a preventable public health tragedy. Adolescent users become adult users, and few people begin to use tobacco after age 18. Current cigarette use among NJ high school students declined sharply during 1997–2003; however, rates have remained relatively stable over the past several years.

In addition to price increases, several strategies can achieve a substantial reduction in youth consumption. These include limiting youth access to tobacco, strong community-based programs concentrating on secondhand smoke, mass media campaigns combined with community-wide interventions, and evidence-based school health programs. However, initiatives to reduce youth smoking must be maintained and accompanied by changes in adult behavior. Policy makers must consider approaches that sustain delayed initiation into adulthood. Comprehensive, effective, and sustainable tobacco-control programs, as well as tobacco cessation programs, are essential to reduce tobacco-caused disease, death and disability.

Annual Report NPM # 13:
A) Percent of women who had a dental visit during pregnancy and
B) Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

The Children's Oral Health Program (COHP) has over a 30-year history of providing interactive, age-appropriate oral health education programs to school-age children throughout the State. During the 2014-2015 school year, approximately 89,000 students in high-risk areas where the water is not optimally fluoridated received oral health/hygiene education and oral health personal care resources. During that school year, over 14,000 students participated in the voluntary school-based fluoride mouth rinse program, “Save Our Smiles,” and over 2,900 kindergarten and first-grade students participated in the Project: BRUSH initiative that engaged the school and local community with oral health messages throughout the year. Other key programs included “Sugar-Less Day to Prevent Tooth Decay” carried out in the 21 counties of the State with over 1,600 fourth-grade students participating. Efforts to target multidisciplinary obstetric, pediatric, medical, nursing and home visiting staff resulted in educating approximately 7,800 providers through train-the-trainer efforts to incorporate oral health care instruction in the patient and home visiting setting.

During 201 5, the NJ Dental Clinic Directory, “Dial a Smile” was updated and the 2016 edition of “Dial a Smile” was distributed to over 3,500 school nurses, WIC sites, summer camps, special needs children’s programs and the NJ Home Visiting Programs in efforts to assist clients in securing a dental home and increasing access to dental care services.

A variety of publications including the "Miles of Smiles" annual school newsletter was mailed to over 3,300 schools, while the "Special Smiles" newsletter was mailed to special services school districts and Special Child Health and Early Intervention Service sites. The "Oral Health Facts for Women, Infants, and Children" newsletter was provided for WIC Coordinators throughout the State.

While the overarching goal of the COHP is to improve the oral health status of school-age children through a variety of interactive oral health education programs, special initiatives are also conducted by the Program. During the 2014-2015 school year, Project: BRUSH an interactive oral health awareness campaign that promotes good oral health practices for children in grades K to 1 reached approximately 2,900 students and included the "Ask a Dental Hygienist" activity. "Sugar-Less Day to Prevent Tooth

Decay" engaged fourth-grade students, school nurses, and art and classroom teachers in themed poster contests. This successful initiative targeted approximately 1,600 students and enjoyed press coverage in major Statewide newspapers.

Project PEDs," Pediatricians Preventing Early Dental Disease" continued to be implemented in select FQHC sites as a train-the-trainer model reaching over 3,100 patients. The initiative highlights the importance of engaging and educating a multidisciplinary pediatric staff regarding the importance of addressing oral health care and referral for dental services during the well child visit.

Project: REACH, "Reducing Early Childhood Caries through Access to Care and Health Education," is an oral health education initiative targeting a multidisciplinary obstetric staff in federally qualified health centers throughout the State reached over 2,100 pregnant women emphasizing the oral-systemic health link and providing resources for dental care referral. Women receive "Oral Health Care Starter Kits" for personal and infant oral health care.

Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program offers comprehensive preventive child health services to all Medicaid-eligible children under age 21 including periodic physical exams; hearing, vision and developmental screenings; lead poisoning screening; vaccines; health education; and dental inspections and referrals. Medicaid in NJ is administered by the Division of Medical Assistance and Health Services (DMAHS) in the NJ Department of Human Services. The performance on this indicator has improved greatly and according to the 2011 Annual EPSDT Participation Report.

Dental initiatives undertaken by DMAHS to promote utilization of dental services include:

Oral Health Stuffer – “Keeping Your Child’s Smile Healthy” was updated in 2012 to indicate age referral to dentist should occur by the age of 1. Language was revised to provide information in layman’s terms while educating the consumer on dental terms.

Dental Advisory Council - meets three times a year, but is also convened for special projects. The Council’s activities include study of priorities, standard of care, quality measures, barriers to care and access strategies, utilization strategies, program benefits and cost of care. The council prepares specific recommendations to DMAHS and interprets goals and policies for professional and community interest groups.

Medical/Dental Directors Meetings – These meetings occur two to three times a year and are a forum to allow DMAHS to communicate directly with the medical and dental directors for the NJFC-MCOs on interpretations, expectations or revisions to policies as set forth in NJ Administrative Code (N.J.A.C.) or the HMO Contract.

Insure Kids Now Website – Information on the dental benefits available to children enrolled with NJFC/Medicaid is posted on this site along with the names and contact information for dentists seeing children by HMO and State Fee for Service.

Annual Report (Last Year's Accomplishments)
National Performance Measure 14:

Initiated in 2001 with funding from the NJDOH-Comprehensive Tobacco Control Program, Mom’s Quit Connection (MQC) is NJ’s maternal child health smoking cessation program. There have been changes in the services provided and their capacity to be a statewide program through the years based on availability of funds. MQC’s trained Tobacco Dependence Specialists utilize a proactive behavior modification model, offering face-to-face individual counseling at the referring health care facility, onsite group counseling or telephone counseling to assist clients in developing a customized quit plan. From July 1, 2013 - June 29, 2014, there were a total 504 referrals to MQC case management: 274 were fax referrals, 32 were self-referrals, and 198 were referred through the PRA system. Of the 139 open MQC clients for this grant year, 70.5% either decreased their consumption or quit smoking. During that same

time 72 face-to-face intakes were completed and 37 telephonic intakes were completed. A total of 2,440 client contacts were made through phone, email, in person or mail. During this year, 106 clients received a total of 380 sessions: 200 sessions were face-to-face and 180 were telephone sessions.

The program was expanded during FY 2015 and Mom's Quit Connection (MQC) was able to develop a multi-pronged and comprehensive statewide approach to perinatal smoking cessation activities. The new activities include:

- Promoting Mom's Quit Connection (MQC) in order to further expand its reach to pregnant and parenting mothers in New Jersey.
- Increasing capacity of Mom's Quit Connection with respect to direct services for pregnant and parenting mothers statewide.
- Preventing relapse after delivery.

MQC provides free onsite Ask, Advise, and Refer Brief Intervention training to maternal-child healthcare providers, hospital staff and physicians, medical and nursing schools, MCH consortia, medical associations, community and social service agencies statewide. Upon completing the training, MQC provides technical assistance to clinicians and office staff in implementing the fax to quit referral process and ongoing cessation support as a routine component of care. In FY 2014, there were a total of 40 educational programs on the dangers of smoking and the risks of exposing children to secondhand and thirdhand smoke with 1,178 participants for this grant year. Staff conducted 31 Ask, Advise, and Refer: Brief Intervention trainings to a total of 284 professionals.

II.F.1.f. Other Program Activities

During CY 2014, the Family Health Line received and assisted 12,427 calls, and made 7,345 referrals. The Reproductive and Perinatal Health Services monitors the grant with the Family Health Line that is a component of the Center for Family Services, Inc. The Reproductive and Perinatal Health Services provides the Family Health Line with consultation, technical assistance and educational material support to facilitate its participation in community events and networking. The Family Health Line employs three clinical staff members who are responsible to answer the Perinatal Mood Disorders Speak Up When You're Down calls. They screen the callers and coordinate working with Mental Health Providers.

II.F.2. MCH Workforce Development and Capacity

NJDOH has identified through the State Health Assessment, the State Health Improvement Plan and the Departments' Five Year Strategic Plan, the need to improve the public health workforce in the areas of access to care, quality improvement, systems integration and population health management. MCH workforce development and capacity is also a priority for the Division of Family Health Services (FHS). As such, the FHS developed and has initiated an MCH Workforce Development and Capacity Plan with the overall goal to prepare present and future maternal and child health workers with the skills and knowledge to succeed in the transformed public health system under the Affordable Care Act. Without an adequately trained MCH staff, vital Title V services and functions would not be provided to meet the needs of the current and future MCH population. Recognizing the value of an experienced and trained staff, the FHS has taken action to improve the capacity of the MCH workforce despite a long-standing hiring freeze.

The FHS implemented the development of succession planning to assure essential functions were considered in long-term planning. During this past fiscal year, cross-training of staff was implemented to assure the ability to maintain key roles in the event of short-term staffing shortages. Changes in the workforce funded by Title V have been quite minimal, reflecting the long-standing MCH priorities and core functions of staff. A Division-wide survey was conducted to identify gaps and needs related to skills development and training. Staff identified several areas such as the need for further training and the development of metrics that are specific to the long-term outcome measurement of maternal and child health in order to maintain the momentum of quality improvement already begun by the NJDOH. Multiple needs were also identified in the areas of data measurement, collection and integration. The majority of staff concurred there was a need for training to help them effectively conduct return on investment (ROI) analyses of MCH programs. As a result of the NJDOH's paradigm shift toward results-based accountability, additional training is needed for staff to become skilled in collecting data appropriate for accountability documentation and to develop accountability metrics to better calculate the ROI for MCH programs tied to public health outcomes. FHS also recognized the need for incorporating the perspectives of families and family representatives into the MCH workforce under the broader umbrella of systems integration. Continued family involvement in health transformation is essential for effective program and policy development related to newly aligned systems.

Critical workforce developmental and training needs of state Title V staff have included extensive training in continuous quality improvement (CQI) to increase the capacity of the workforce to understand, select and use QI methods and tools but also to foster a CQI culture at FHS and eventually to the local agencies that are funded by MCH Block. We have already seen the positive results of this training through the participation of staff in the Collaborative Improvement and Innovation Network (CoIIN) to Reduce Infant Mortality, and the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program. Given the diversity of our state, cultural competency trainings continue to be provided to staff as an essential component of their continuing education activities. Other available opportunities have been pursued through trainings offered at national conferences including AMCHP, the MCH Epidemiology Conference, and the MCH Public Health Leadership Institute. Departmental trainings have been offered on Ethics, grant writing, and grants management. Opportunities to supplement staffing through student internships, special temporary assignments, fellowship programs and state assignees have also been successful.

While the NJDOH and the FHS have taken proactive steps in creating a learning organization by providing workforce development opportunities, there is still a need for specialized in-house training and educational programs specific to the identified needs of our MCH workforce. Therefore, the Division is in the process of developing a Memorandum of Agreement with the Rutgers School of Nursing and Rutgers School of Public Health to develop training programs that offer continuing education credits to public health, social work and nursing professionals currently employed by the Division that should be in place by November of 2015. The specific contents of the workshops are still being developed. Some areas being discussed are how to build new relationships and develop successful strategic alignments with partners from other sectors; identification and utilization of practical tools to guide informed and intentional decision making in the context of current and changing systems that impact MCH populations; systems science and systems tools that can effectively bridge traditional workforce silos and contribute to

multisector policy discussions to achieve collective impact; and how to effectively define concepts related to systems, and map systems to identify gaps and leverage points in current program development for MCH populations. The outcomes to be achieved through a well-defined succession of workshops will be for an MCH workforce that can effectively use systems tools to assist in informed decision making and better alignment of resources and programs; improved capacity to use systems integration resources to provide a source of leverage for Title V expertise, especially regarding life course theory and its application to programs beyond maternal and child health; and to effectively integrate MCH into both the work of public health and the health care system by fully integrating the Life Course perspective more broadly.

The focus on workforce development will continue to be a pivotal component of FHS operations. As such, each staff person has as a requirement under their individualized Performance Assessment Report, a criterion to include a professional development plan for each yearly rating period (October 1 to September 30).

FHS recently evaluated its current and future workforce requirements for the State's MCH Services. The evaluation resulted in reclassification of titles to meet the needs of the changing roles and requirements and keeping aligned with NJDOH's strategic plan. FHS hired employees and are hiring new employees in the title series of Health Data Specialist and Analyst, Research and Evaluation to support the MCH Epidemiology and SCHEIS Programs. Additionally, we are preparing to hire additional Quality Assurance Specialists. Hiring employees in these titles will improve effectiveness and efficiency of the public health system especially in the MCH programs. The vacant positions resulted from retirements, resignations and promotions.

The workforce capacity of MCH service units and programs is described previously in section II.B.2b.ii (Agency Capacity) and Section II.B.2b.iiI (MCH Workforce Development and Capacity). This section more completely describes FHS's capacity to promote and protect the health of all mothers and children, including children and youth with special health care needs (CYSHCN). The Maternal and Child Health Services (MCHS) and Special Child Health and Early Intervention Services (SCHEIS) Units ensure a statewide system of services that reflect the principles of comprehensive, community-based, coordinated, family-centered care through collaboration with other agencies and private organizations and the coordination of health services with other services at the community level.

The mission of the FHS is to improve the health, safety, and well-being of families and communities in NJ. The FHS works to promote and protect the health of mothers, children, adolescents, and at-risk populations, and to reduce disparities in health outcomes by ensuring access to quality comprehensive care. Our ultimate goals are to enhance the quality of life for each person, family, and community, and to make an investment in the health of future generations.

Table 1d - Title V Program Capacity and Collaboration to Ensure a Statewide System of Services (See Supporting Document #1) summarizes according to the six MCH population health domains the collaborations with other state agencies and private organizations, the state support for communities, the coordination with community-based systems, and the coordination of health services with other services at the community level.

II.F.2. Preventive and Primary Care for Pregnant Women, Mothers and Infants

The mission of Maternal and Child Health Services (MCHS) within FHS is to improve the health status of New Jersey families, infants, children and adolescents in a culturally competent manner, with an emphasis on low-income and special populations. Prenatal care, reproductive health services, perinatal risk reduction services for women and their partners, postpartum depression, mortality review, child care, early childhood systems development, childhood lead poisoning prevention, immunization, oral health and hygiene, student health and wellness, nutrition and physical fitness and teen pregnancy prevention are all part of the MCHS effort. The population Domains addressed by MCHS include 1, 2, 3, 4, and 6.

Reproductive and Perinatal Health Services (RPHS), within MCHS, coordinates a regionalized system of care of mothers and children in collaboration with the Maternal and Child Health Consortia (MCHC). The MCHC were developed to promote the delivery of the highest quality of care to all pregnant women and newborns, to maximize utilization of highly trained perinatal personnel and intensive care facilities, and to promote a coordinated and cooperative prevention-oriented approach to perinatal services. Continuous quality improvement activities are coordinated on the regional level by the MCHC.

Promoting a Life Course perspective, a new request for proposals (RFP) was issued in January 2014 by RPHS and awarded last year called the Improving Pregnancy Outcomes (IPO) Initiative which targeted limited public health resources to populations and communities with the highest need to improve quality access to prenatal care, preconception and interconception care as a means to decrease infant mortality rates. Using two models, Community Health Workers and Central Intake, the IPO Initiative will work to improve specific maternal and infant health outcomes including preconception care, prenatal care, interconceptual care, preterm birth, low birth weight, and infant mortality through implementation of evidence-based and/or best practice strategies across three key life course stages: preconception, prenatal/postpartum and interconception.

Also focused on Increasing Healthy Births and improving pregnancy outcomes is the work of NJ as a participant in the National Governors Association Improving Birth Outcomes and the Infant Mortality CoIIN. NJ was awarded the opportunity to participate in the National Governors Association (NGA) Center for Best Practices' Learning Network on Improving Birth Outcomes. This initiative enabled NJ to explore evidence-based strategies shown to be effective in addressing poor birth outcomes. Participation in this NGA Learning Network afforded the NJDOH the opportunity to hold an in-state meeting on January 13, 2014 to explore these critical issues and to set the agenda for the future. The meeting of public and private partners provided a wider awareness of NJ's prematurity rates and other related maternal and child health indicators and discussed the steps necessary to further move the needle on these important health indicators. Partnering departments included the Department of Children and Families, Human Services (Medicaid) and Education.

MCHS has embraced the Fetal Infant Mortality Review (FIMR) Program as a mechanism for quality improvement and improve the system of care to promote healthy births. FIMR is one of the original American College of Obstetricians and Gynecologists (ACOG) Partnership projects. The overall goal of NJ FIMR is to establish a statewide system of fetal-infant mortality review by implementing or expanding FIMR projects with each of the 3 regional MCH Consortia. NJ follows guidelines for planning and implementing community fetal and infant mortality review developed by the National Fetal-Infant Mortality Review Program (NFIMR). The projects use standardized data collection, entry and reporting methods to ensure consistency of the review process throughout the State. This includes using data abstraction and case review summary forms developed by NFIMR and modified by NJ FIMR. NJ is participating with NFIMR as one of the states beta testing the new database.

The NJ Maternal Mortality Review Team is part of a longstanding commitment among healthcare professionals and other concerned citizen to reduce and prevent the number of deaths related to pregnancy and childbearing among NJ residents. A multidisciplinary review team is utilized and the primary focus of the Case Review Team is to identify systems related issues. Recommendations for systems improvement are shared with healthcare professionals and the public through the Maternal Mortality Report. Team recommendations are also used for program planning at the NJDOH.

The major goals of the Perinatal Addictions Prevention Project (PAPP) include providing professional and public education, encouraging all prenatal providers to screen all of their pregnant patients for substance use/abuse and developing a network of available resources to aid pregnant substance using/abusing women. Risk-reduction coordinators working with this project provide ongoing regional professional training, individual on-site training, technical assistance and monitoring, grand rounds training, networking, and a link between regional and local services relating to prenatal substance use/abuse.

Approximately 30% of the pregnant women in NJ were screened for substance use during the past year according to the Perinatal Risk Assessment volume numbers. The majority of these patients were seen

at public clinics. Referral information is given to those women who are smoking, using drugs and/or alcohol and those who have possible domestic violence issues. Last year there were 125 education programs held for over 1,458 professionals. There were 646 programs held to educate the general public and approximately 16,290 people participated.

NJ successfully applied in 2010 for the Maternal, Infant and Early Childhood Home Visiting Program (MIEC HV) Formula and Competitive Grants to the Health Resources and Services Administration. The goal of the NJ MIEC HV Program is to expand NJ's existing system of home visiting services which provides evidence-based family support services to: improve family functioning; prevent child abuse and neglect; and promote child health, safety, development and school readiness. Full implementation of the grant project is being carried out in collaboration with the Department of Children and Families (DCF). Currently evidence-based home visitation services are provided by 67 Local Implementing Agencies (LIAs) providing three national models (Healthy Families America, Parents As Teachers and Nurse Family Partnership) in all 21 NJ counties serving approximately 6,000 families in SFY 2014.

Through the Post-Partum Depression Initiative, education has been provided to over 6,000 healthcare providers. Hospitals and private practitioners are receiving assistance with implementing the law that requires screening and education at specified intervals during the perinatal period. NJDOH offers a PPD helpline (1-800-328-3838) that operates 24 hours per day, seven days a week to provide resources and information to women and their families and friends. In addition, a dedicated Web site (www.njspeakup.gov) provides educational materials such as brochures, videos, books, support groups, FAQs, and other helpful Web sites on postpartum depression and other perinatal mood disorders.

The NJDOH continues to support the provision of Family Planning via a grant with the New Jersey Family Planning League to ensure that family planning services are available in all 21 counties in NJ. Family Planning agencies provide services in cooperation with other NJDOH initiatives according to Title X national guidelines including: family planning and related preventive health services, such as natural family planning methods; HIV/AIDS and sexually transmitted infections prevention and treatment; services to adolescents; cancer screening (including breast and cervical cancer); nutrition education; preconception and interconception care; infertility services; and counseling on establishing a reproductive life plan.

II.F.2. Preventive and Primary Care for Children and Adolescents

The Child and Adolescent Health Program, within MCHS, focuses on primary prevention strategies involving the three MCH domains of Child Health, Adolescent/Young Adult Health, and the Life Course.

An emphasis in Child Health is the prevention of lead poisoning among children under six years of age through collaborative, prevention-oriented outreach and education to parents, property owners, and health care providers. The Childhood Lead Poisoning Prevention (CLPP) Projects use a home visiting model to provide nurse case management and environmental investigations for children less than six years of age with confirmed elevated blood lead levels. Thirteen sites throughout the State receive funding to provide monitoring of retesting of elevated blood lead levels, to perform household education and conduct residential property inspections to identify and abate lead hazards. The goal of the CLPP Projects are to promote a coordinated support system for lead poisoned children and their families through the development of stronger linkages with Special Child Health Services, Medicaid Managed Care Organizations (MCOs), DCF, DOE, Department of Community Affairs, and community-based agencies that provide early childhood services.

Services include a healthy homes assessment tool so that additional health and safety issues in the home can be identified and remediated so that homes are free of disease-causing agents and sources of preventable injuries. NJDOH has established a partnership with MIEC Home Visiting programs that provide services for pregnant women, infants, young children, in addition to resource family homes that provide a safe residential environment for children who are in the foster care system.

Grants are provided to 13 local health departments, with the highest number of cases, to support the provision of nursing case management and environmental investigation services. In addition, Child Health provides grants to three agencies to administer regional coalitions, serving every county in NJ, to provide prevention-focused education and training to parents, caregivers of young children, and property owners and renters. The NJDOH co-administers the New Jersey Healthy Homes Training Center which provides training to health, social services and housing professionals. In partnership with the American Academy of Pediatrics/NJ Chapter, Child Health promotes a nationally-recognized medical home model.

Public outreach and professional education on lead poisoning prevention, using a healthy homes approach, is conducted by three Regional Lead and Healthy Homes Coalitions. From May 2012 to August 2014, a pilot using the LeadCare II point-of-care blood lead analyzer was used by self-selected local health departments. The success of the project serves as the foundation for the Superstorm Sandy recovery project's blood lead screening initiative in nine most impacted counties.

Since July 2010, Adolescent Health has been working to implement the CDC Coordinated School Health (CSH)/Whole School, Whole Community, Whole Child (WSCC) model. One Full Time Equivalent (FTE) professional staff person is assigned responsibility for this project and the position is currently vacant. The CDC model provides a framework for organizing school health into 10 components: 1) Health Education, 2) Physical Education, 3) Health Services, 4) Counseling, Psychological and Social Services, 5) Nutrition Services, 6) Staff Wellness, 7) Healthy Physical School Environment, 8) Healthy Social-Emotional School Climate and Culture, 9) Family Engagement, and 10) Community Involvement. School health programs promote healthy behaviors and health is critically linked to academic performance. Self-reported health behaviors (alcohol, tobacco and other drug (ATOD) use; healthy food choices; physical activity; sexual activity; and, violence, injury and safety) of high school youth are surveyed every other (odd numbered) year using the NJ Student Health Survey.

Three processes are integral for successful implementation of the CSH/WSCC model: 1) establish a School Health Team; 2) assess the school's health policies, programs and practices using CDCs School Health Index (SHI) assessment tool; and, 3) develop, implement and evaluate an action plan based on the results of the assessment. Coordination of these ten components identifies gaps, avoids duplication of activities and improves the efficiency and effectiveness of health programs and services available in the school system.

The current CSH regional grantee agencies, selected through a competitive application process, are responsible for the administrative oversight, training, technical assistance and resource support needed by funded or interested public schools, grades six and above in their respective northern, central or southern region. The goal of this project is to improve the health (physical, mental, emotional and social) well-being of students and school staff and strengthen the health and safety of the school environment. Currently, these regional grantee agencies fund schools to implement evidence-based or best practice school health actions.

Sustainability of healthy school practices and programs can be ensured through community involvement, parent and youth engagement and policy. The Statewide Parent Advocacy Network (SPAN) is funded to implement "Parents as Champions (PAC) for Healthy Schools." This training empowers parents as "agents of change" to facilitate parental action in promoting healthier schools. This project also partners with various state, local and statewide professional organizations to collaborate on improving school and student health to improve their learning and consequently, their life success.

On October 1, 2013, Community Health and Wellness Services was awarded the CDC cooperative agreement DP1305 for the basic and enhanced components of "State Public Actions to Prevent Chronic Disease and Promote School Health." A staff person was recently hired and assigned to work on the school health strategy and coordination between the two service units is planned.

The CAH Program successfully applied for and was awarded two new federal grants to prevent teen pregnancy in 2010. The New Jersey Personal Responsibility Education Program (NJ PREP) enables six grantees to replicate evidence-based programs that have proven effectiveness in changing behaviors to

delay sexual activity, increase condom or contraceptive use for sexually active youth, or reduce pregnancy among youth. NJ PREP funding also provides education on at least three of the following adult preparation topics: healthy relationships; positive adolescent development; financial literacy; parent-child communication skills; education and employment preparation skills and healthy life skills. NJ PREP grantees implement seven evidence-based sexual health education programs: Be Proud Be Responsible; Be Proud Be Responsible Be Protective; Making Proud Choices; Reducing the Risk; SiHLE; Teen Health Project; and Teen Outreach Program. In SFY 2014, NJ PREP was successfully implemented by six sub-grantees at more than 60 locations (27 community-based organizations and 34 school-based organizations) in 24 municipalities and 12 counties throughout NJ reaching approximately 2,300 unduplicated youth participants.

The NJ Abstinence Education Program (NJ AEP) funds four grantees to provide abstinence-only education to adolescents that are at high-risk for teen pregnancy, STDs/STIs and HIV/AIDS. The NJ-AEP is a primary prevention strategy that provides 10- to 14-year-olds the knowledge and skills to avoid the high-risk behavior of early sexual activity and promotes abstinence from sexual activity and, where appropriate, provides options that may include mentoring, counseling and/or adult supervision.

The website - "NJ Parent Link, New Jersey's Early Childhood, Parenting and Professional Resource Center" http://www.njparentlink.nj.gov was launched in June 2010 as a web-based resource for consumers and professionals. The website is designed to function as the IT gateway for all State-based services and resources for expectant parents, families with children and NJ children's health, education and welfare professionals. NJ Parent Link includes direct linkages to 15 NJ State executive departments, the Governor's office, the legislative and judicial branches, as well as federal and community resources.

Community-building features include: county contacts & local links listings; tailored subscription services; continuing education/professional development announcements; a children's art gallery; an easy-to-navigate En Espanol feature and a translation service for over 50 languages. Numerous data collection and quality assurance markers are woven throughout the website's features to maximize assessment capabilities and real time opportunities for collaboration and coordination of shared goals and resources within the early childhood community. Total number of NJ Parent Link website hits from 1/1/2013 to 4/1/2015 was 725,837. In March 2015, 7,625 unique visitors accessed information from the NJ Parent Link website.

II.F.2. Preventive and Primary Care for Children with Special Health Care Needs

NJ maintains a comprehensive system to promote and support access to preventive and primary care for CYSHCN through early identification, linkage to care, and family support. Title V partially supports this safety net which is comprised of pediatric specialty and sub-specialty, case management, and family support agencies that provide in-state regionalized and/or county-based services. It is designed to provide family-centered, culturally competent, community-based services for CYSHCN age birth to 21 years of age, as well as to enhance access to medical home, facilitate transition to adult systems, and health insurance coverage. The Specialized Pediatric Services Programs (SPSP) agencies are a significant resource of pediatric specialty and subspecialty care in NJ, and are used widely by CYSHCN including Medicaid recipients. Although clients are screened for their ability to pay for clinical services, the support provided by Title V enables all CYSHCN to be served regardless of their ability to pay. There is no charge for SCHS CM and family support.

Administratively housed in the Family Centered Care Services (FCCS) Unit these services include 21 county-based Special Child Health Services Case Management Units (SCHS CMUs), one Family Support project, and multiple Specialized Pediatric Services Programs (SPSP); 9 Child Evaluation Centers (CECs) of which 4 house Fetal Alcohol Syndrome Disorder Centers, and 3 provide newborn hearing screening follow-up, and 5 Cleft Lip/Palate Craniofacial Anomalies Centers and a small State operated Fee-for-Service program. Likewise, State and federal collaborations among the FCCS programs and non-Title V funded programs such as the Ryan White Part D Family Centered HIV Care Network (RWPD), Early Intervention System (EIS), Federally Qualified Health Centers (FQHC), medical home initiatives,

Supplemental Security Income (SSI), Catastrophic Illness in Children Relief Fund (CICRF) and other community-based initiatives extend the safety net through which Title V links CYSHCN with preventive and primary care.

CYSHCN are referred into NJ's preventive and primary system of care through mandatory and/or informal pathways. Mandatory reporting by medical providers is required for infants/children that rule in for reportable conditions identified via the Newborn Biochemical Screening and the Birth Defects and Autism Registry Services programs, and in NJ reporting is linked to access to care. The expansion of newborn biochemical screenings to 55 reportable disorders reinforces the continued need to maintain an in-state body of providers to treat children with these conditions, as well as a potential increase in number of referrals to the SPSP agencies, subsequent reporting to the BDARS, follow-up by SCHS CM and the provision of family support. Receipt of referral by the BDARS results in outreach by the SCHS CMUs, whereby families are offered follow-up and linkage to services. Follow-up is recorded in the electronic Case Management Referral System (CMRS), which provides a system for Title V to review and analyze follow-up. Likewise, the SCHS CMUs and SPSP agencies submit registrations of CYSHCN with reportable conditions to the BDARS. Additional formal referral mechanisms that result in linkage to the SCHS CMUs includes the State Data Exchange of SSI applicants under age 16 years and CICRF applicants. Informal linkages to SCHS CM and/or SPSP include self-referral by families, and referral by community-based family support and providers for pediatric specialty/subspecialty outpatient care.

Through Title V support, each of NJ's 21 counties maintains an SCHS CMU partially funded by its Board of Chosen Freeholders to promote access to preventive and primary care for CYSHCN. With parental consent, SCHS CMUs work with the child's parents, physician and/or specialists to evaluate an affected child's strengths and needs; and collaborates with the family and community-based partners to develop an individual service plan (ISP) for the child and family. Medical, educational, rehabilitative, developmental, social, emotional and economic needs of the child and family are targeted. Statewide SFY 2015 data indicate that 14,029 CYSHCN were served, 8,908 ISPs developed, 5,5704 SSI referrals received and 3,679 CYSHCN were on SSI. The age distribution indicates that the majority of CYSHCN served are age 5-13 years (45%), age 1-4 years (21%), birth to 364 days (18%), age 14-19 years (14%), and those over age 20 (2%). Nearly 98% served are documented to have insurance, of which 61% are enrolled in a Medicaid managed care organization. Approximately 26% self-identify as Hispanic, and race data indicates 49% white, 15% black, 4% Asian, 6% more than one race, 4% other, and 21% unknown. Quality assurance is underway to reduce the number reported as unknown. All SCHS CMUs are required to assess the health care needs and insurance status of CYSHCN served.

State Title V staffs, SCHS CMUs and SPSP providers, and SPAN Family Resource Specialists receive training from State agencies such as the NJ Department of Human Services, and the Department of Children and Families to become Informal Application Assistors for Medicaid/NJ FamilyCare programs as well as to learn about Managed Long Term Services and Supports, how to care through the Marketplace, and behavioral services through PerformCare. These trainings build capacity among Title V agency providers to enhance access to primary and preventive care for CYSCHN. For example, an SCHS CM reported being able to assist a parent to problem solve a denial of home health aide services for a 12-year-old with autism and significant developmental delays by advocating on Mom's behalf with PerformCare, her child's school district, and her Family Support Organization. Repeated phone calls, home visits, and written appeals by the SCHS CM supported Mom's efforts to clarify the missing information and resolve her child's needs.

Recognizing that SCHS CM and family support are valuable in assisting families of CYSHCN to access care, Title V works collaboratively with the SCHS CMUs and family support organizations, including Family WRAP (Wisdom, Resources, and Parent to Parent.) Specific Family WRAP programs include Project Care, Parent-to-Parent and Family Voices New Jersey. SPAN and SCHEIS have continued to identify/develop resources to expand the number of Family Resources Specialists (FRS) trained as support specialists to work on site at the SCHS CMUs or regionally. In SFY 2014, Family WRAP projects including the supplemental Superstorm Sandy family support provided over 38,000 parent/professional contacts. Through supplemental funding provided by the federal Parent Training Information Center (PTI) and Superstorm Sandy Block Grant, additional FRSs have been added for statewide support. In addition,

Title V, Early Intervention Systems, SPAN, and other community-based partners are collaborating on an AMCHP sponsored "Learn the Signs. Act Early." initiative.

Through collaboration with SPAN, the NJ Academy of Pediatrics' Pediatric Council on Education and Research (NJ AAP), SCHS CMUs, SPSP providers, and the Community of Care Consortium efforts are ongoing to improve access to coordinated preventive and primary care through medical home. NJ Title V supports a project with NJ AAP to expand and build NJ's capacity by having the NJAAP/Medical Home Quality Improvement Team become NCQA Recognized Experts and by staffing an "NCQA Recognition Warm Line" available to Pediatricians across the State. The SPSP, SCHS CMU, and Family WRAP projects will continue to collaborate and provide technical assistance to providers participating in this initiative.

Preventive and primary care services are in demand and most recent data indicate that an 1% increase in CYSHCN served was noted across SPSP services; 60,530 (SFY2014) vs. 61,243 (SFY2015). Comprehensive multidisciplinary team evaluation is provided through the CECs to assess the needs of children with congenital or acquired neurodevelopmental disorders including communication, learning, and behavioral disorders. A copy of the team-based plan of care is provided to the family of the CYSCHN and/or their primary care physician of record. In 2015, 31,144 CYSHCN were seen at the CECs for multidisciplinary evaluations including FAS, and the most frequently diagnosed conditions include Attention Deficit Hyperactivity Disorder (ADHD) (27%), Autism (13%), Developmental Delays (12%), Speech Disorders (11%), and Psychiatric Disorders (10%). Furthermore, more than 54,790 visits were reported. Of note, 49% CYSHCN served were enrolled in one of the Medicaid programs and less than 1% were uninsured.

Access to in-state pediatric specialty and subspecialty care is further provided through NJ's Cleft Lip/Palate Craniofacial Anomalies Centers and Tertiary Care Centers. Multidisciplinary teams ensure that patients receive necessary medical, nutritional, and developmental care, and that there is coordination of care with primary care providers, sub-specialists, hospitalists, and other community-based providers such as FQHCs. A total of 29,886 CYSHCN received evaluations and services through the five Craniofacial Centers and three Tertiary Centers in 2015. SFY 2015, data indicate that 1,976 CYSHCN were served through the Cleft Centers, of which 56% were insured through State Medicaid program; 35% had some form of private insurance, and 1% of children's insurance status was reported as uninsured/unknown. Approximately 39% were under the age of 1 and nearly 31% were age 5-13 years, reinforcing the need for continuation of coordinated care through school age. Coordination with community-based dental providers including orthodontia remains a challenge, and collaboration with patients' care management organizations is helpful to resolve access. The Tertiary Centers reported over 27,910 clients served in SFY 2015, with the majority (39%) reported as age 5-13 years. Again these Centers of Excellence as noted in the NJ Medicaid Managed Care Contract fill a need for specialty care providers that accept Medicaid with nearly 62% served reported being enrolled in a NJ Medicaid/NJ FamilyCare program, and only 1% were uninsured, and less than 1% paying for care on a sliding scale. Specialty services in greatest demand during that same time period include; Cardiology (16%), Gastroenterology (11%), Neurology (10%), Oncology (10%), Endocrinology (7%) and Radiology (7%).

This complement of Centers fills a critical in-State need for access to pediatric specialty and subspecialty care, and the providers are vested in providing family centered care. A family satisfaction survey was launched in 2015, to gather family input on their experiences with services and access to care. Although data is under review, preliminary findings are described in State Overview.

To ensure family participation and address cultural competency, the Centers provide written informed consent guidelines for all aspects of the evaluation, diagnostic and/or treatment services. The confidentiality of records is protected, written procedures regarding access to records is made available to all staff, and the sharing of records is determined by the parents of CYSHCN. Each Center maintains written procedures for parental consent for release of records. The Centers must comply with the Americans with Disability Act (ADA) requirements. Limited English proficiency needs are addressed through access to foreign language interpreters and/or interpreters for the deaf. Of note, the SFY 15 family satisfaction survey administered to families of children who received services through an SPSP

provider indicated a significant number of English as second language respondents. Of the nearly 800 surveys administered, 17% were completed in Spanish. This small but significant finding reinforces the value of language and cultural support. The Centers cannot discriminate through admission policies, hiring practices, or promotional opportunities on the basis of race, religion, ethnic origin, sex or handicapping conditions. CYSHCN with ongoing needs that warrant care coordination are linked with the SCHS CMU located in their county of residence.

Through the Fee-For Service (FFS) program State Title V staffs and county-based Special Child Health Services Case Managers (SCHS CM's) process requests for assistance with uncovered expenses for medically necessary services such as hearing aids, braces, orthotics, prostheses, and medications to treat asthma and cystic fibrosis. In SFY 2014, 50 CYSHCN received benefits through FFS. 100% of FFS applications are screened for NJ Medicaid, NJ FamilyCare, and/or accurate interpretation of their commercial health coverage and are referred to their county SCHS CMU for supports. The demand for assistance to purchase hearing aids for youth age 18-21 has gradually increased. NJ's Grace's Law and the Affordable Care Act (ACA) have improved coverage, an example being that hearing aid coverage is now considered an essential health benefit. However some families continue to experience gaps in coverage and require assistance through FFS, for example, those with grandfathered plans, certain employer-sponsored plans, and those ineligible for State programs due to residency have found that some challenges remain. Likewise, challenges continue for CYSCHN, families, and providers, in understanding insurance benefits and how to use them, particularly for families with limited English proficiency. Title V staffs, the SCHS CMUs, and SPAN Family Resource Specialists are instrumental in assisting CYSCHN to understand and use their coverage. For example, with the implementation of Grace's Law in 2008, certain health benefit plans were mandated to provide limited coverage of $1,000 per hearing aid for children 15 years and younger every 24 months. Subsequently, the ACA prohibited annual or lifetime benefit limits on essential health benefits. Consequently, the inclusion of hearing aids as an essential health benefit is a strength for families of CYSHCN; however, the NJ specific $1,000 benefit limit no longer applies. This change presents the potential for an increase in out-of-pocket expenses for some CYSHCN, and challenges for hearing aid dispensers to renegotiate reimbursement with insurance carriers. To that end, State Title V staffs, the Early Hearing Detection and Intervention Audiologist, and SCHS CM's provide technical assistance to applicants, providers, insurance providers, and Human Resource departments as needed.

A priority for SCHEIS is ensuring rehabilitative services for blind and disabled individuals less than 16 years old receiving services under Title XIX. Historically, SCHEIS has addressed the early identification, outreach to and the support of that special needs population through follow-up of CYSHCN by the SCHS CMUs. Typically, CYSHCN age birth to 21 years of age are identified to the SCHS CMUs in the county in which the CYSHCN resides through the BDARS and the CICRF; by community, family and self-referrals; and through the Department of Human Services transmittal of Social Security Administration's Supplemental Security Income (SSI) data provided via the State Data Exchange.

The SSI transmittal is electronic and enables the NJDOH to conduct monthly uploads of county-specific reports which are then viewable by the SCHS CMUs through the NJDOH's secured web access. The SCHS CMUs outreach to all CYSHCN referred by SSI to offer information and referral; development of an ISP; case management services as needed; linkage with community-based primary and pediatric specialty care, transition to adulthood, family support and social service supports across local, State, and federal programs. With electronic access to their county-specific reports, the SCHS CMUs manage their workflow. In addition, receiving the data electronically has enabled SCHEIS to more accurately track the numbers of CYSHCN referred and served. State FCCS staffs monitor the transmittal and follow-up of SSI referrals by the SCHS CMUs, and status of follow-up has been included as an indicator on the SCHS CMU evaluation tool.

II.F.3. Family/Consumer Partnership

Building the capacity of women, children and youth, including those with special health care needs, and families to partner in decision making with Title V programs at the federal, state and community levels is a critical strategy in helping NJ to achieve its MCH outcomes. FHS has several initiatives to build and strengthen family/consumer partnerships for all MCH populations, to assure cultural and linguistic competence and to promote health equity in the work of NJ's Title V program.

Efforts to support Family/Consumer Partnerships, including family/consumer engagement, are in the following strategies and activities:
• Advisory Committees;
• Strategic and Program Planning;
• Quality Improvement;
• Workforce Development;
• Block Grant Development and Review;
• Materials Development; and
• Advocacy.

This section summarizes the relevant family/consumer and organizational relationships which serve the MCH populations and expand the capacity and reach of the state Title V MCH and CYSHCN programs. **Table 1f** - MCH Organizational Relationships with Partnerships, Collaboration, and Cross-Program Coordination (See Supporting Document #1) summarizes the partnerships, collaborations, and cross-program coordination established by the state Title V program with public and private sector entities; federal, state and local government programs; families/consumers; primary care associations; tertiary care facilities; academia; and other primary and public health organizations across the state that address the priority needs of the MCH population but are not funded by the state Title V program.

The public health issues affecting maternal and child health outcomes generally affect low-income and minority populations disproportionately and is influenced by the physical, social and economic environments in which people live. To address these complex health issues effectively, FHS/Title V program recognizes that a spectrum of strategies to build community capacity and promote community health must include parents and consumers representing the affected populations as integral partners in all activities in order to have full community engagement and successful programs. In order to carry out these functions and address the public health disparities affecting NJs maternal child health population, FHS/Title V program has incorporated consumer/family involvement in as many programs and activities as appropriate.

NJ has prided itself on its regional MCH services and programs, which have been provided through the Maternal Child Health Consortia (MCHC), an established regionalized network of maternal and child health providers with emphasis on prevention and community-based activities. Partially funded by FHS, the MCHC are charged with developing regional perinatal and pediatric plans, total quality improvement systems, professional and consumer education, transport systems, data analysis, and infant follow-up programs. The three MCHC are located in the northern, central and southern regions of the state. It is a requirement of the statute governing the MCHC that 50% of their Board of Directors be comprised of consumers representing the diverse population groups being serviced by their organizations.

Recognizing the importance that parent/consumer involvement has in the design and implementation of a program to address issues related to preterm births and infant mortality, the MCH Program incorporated parent/consumer involvement into an FHS major initiative, the Improving Pregnancy Outcomes Project (IPO), which requires grantees to have a Consumer Advisory Council to help guide the program, assist with the evaluation and quality improvement initiatives as well as the design and development of all educational/information materials. Similarly, the Home Visitation Program (MIEC-HV) also requires funded grantees to implement Consumer Advisory Work Groups.

The NJ Title V CYSHCN Program, also referred to as Special Child Health and Early Intervention Services (SCHEIS), partners, collaborates, and coordinates with many different governmental and

nongovernmental entities, on federal, state, and local levels, as well as parents, families and caregivers, primary care physicians, specialists, other health care providers, hospitals, advocacy organizations, and many others to facilitate access to coordinated, comprehensive, culturally competent care for CYSHCN. SCHEIS works with programs within the NJ Departments of Human Services (DHS) and Children and Families (DCF) in addressing many needs facing CYSHCN including medical, dental, developmental, rehabilitative, mental health, and social services. DHS administers Title XIX and Title XX services and provides critical supports for ensuring access to early periodic screening detection and treatment for CYSHCN. The State DHS Medicaid, Children's Health Insurance Program Reauthorization Act (CHIPRA) NJ FamilyCare Program, and the Division of Disability Services afford eligible children comprehensive health insurance coverage to access primary, specialty, and home health care that CYSHCN and their families need. SCHEIS utilizes patient satisfaction survey as a means to improve and refine. All trainings provided to grantees are also open to parents/consumers as either participants and or speakers. All CYSHCNs educational materials and informational brochures receive input and are reviewed by parents/consumers for health literacy and cultural competence.

SCHEIS collaborates with many offices and programs in DHS to develop and implement policy that will ensure that children referred into the SCHS CMUs and their families are screened appropriately for healthcare service entitlements and waivered services. SCHEIS programs including case management, specialized pediatrics, and Ryan White Part D, screen all referrals for insurance and potential eligibility for Medicaid programs, counsel referrals on how to access Medicaid, NJ FamilyCare, Advantage, and waiver programs, and link families with their county-based Boards of Social Services and Medicaid Assistance Customer Care Centers. Program data including insurance status is collected put into a report which is compared with Medicaid data in determining CYSHCN need. Referrals are made to Boards of Social Services, NJ Family Care, Advantage, Charity Care, Department of Banking and Insurance, and Disability Rights NJ for support and advocacy.

The Early Hearing Detection and Identification (EHDI) program within the SCHEIS also recognizes the pivotal role that consumers and parents play in the effective administration of the program. EHDI has an Advisory Council composed of parents of deaf and hard of hearing children and consumers who themselves are deaf or hard of hearing. Participants on the council take part in literature reviews, advise the NJDOH regarding innovations in the programmatic area and assist in the review of operations of the program.

Collaboration between SCHEIS staff, SCHS CM and/or Specialized Pediatric Services providers and the DHS, Division of Family Development (DFD) is essential in coordinating access to care and social services for many of NJ's most vulnerable CYSHCN and their families. The primary tasks of DFD include directing NJ's welfare program, Workfirst NJ (WFNJ), and providing funding, information management services, and administrative support to the county and/or municipal welfare departments that implement the federally funded Food Stamps food assistance program. The DFD also oversees child care licensing, Kinship supports for families, and child support. The federal SSI benefit program for aged, blind or disabled individuals is also supplemented by DFD. WFNJ recipients who may be eligible for federal SSI benefits can now get free legal help. The DFD has established an agreement with Legal Services of NJ (LSNJ) to assist recipients in either filing for SSI benefits or appealing a denial of benefits.

The DHS Division of Disabilities Services (DDS) and SCHEIS collaborate to promote and facilitate independence and participation for people with disabilities in all aspects of community life. Through its system of Information and Referral (I&R), the DDS supports active information exchange regarding community services and fosters coordination and cooperation among government and community-based agencies. The I&R Specialists commonly refer families of CYSHCN to the SCHEIS CECs, Tertiary Care Centers and Cleft Lip/Palate and Craniofacial Anomalies Centers; SCHS CMUs and family supports. In addition, SCHEIS refers families to the Traumatic Brain Injury (TBI) Fund, TBI Waiver and Personal Preference: NJ Cash and Counseling Program; and the Medicaid Personal Care Assistant (PCA) services. The SCHEIS regularly uses these DDS resources to assist families of CYSHCN to find health and transition to adulthood supports.

In operation for over 20 years, the Catastrophic Illness in Children Relief Fund (CICRF) Commission administers a financial assistance program for NJ families whose children have an illness or condition otherwise not fully covered by insurance, State or Federal programs, or other source. By legislative mandate, SCHEIS participates on the CICRF Commission.

P.L. 1987 C.370 established the CICRF Commission in the Executive Branch of the State Government to administer the Fund and establish a program by which the public may have access to this financial resource. Though placed under the DHS the CICRF Commission is independent of the departments' supervision or control. The Commission consists of 12 members, 7 of whom are appointed from the public (consumers/parent representatives) and are non-salaried. A public member, elected by the Commission is Chairperson. The other 5 members are the Commissioners of Human Services, Health/FHS, Banking and Insurance, Children and Families, and the State Treasurer.

SCHEIS maintains a memorandum of agreement with the CICRF program to formally refer children birth to 21 years of age whose families have accumulated medical debt for the care and treatment of their children's medical condition. All applications received by the State CICRF program are forwarded to the SCHS CMU in the CYSHCN's county of residence for intake, information and referral, individualized service plan development, intermittent monitoring of needs, and registration with the BDARS.

The NJ Council on Developmental Disabilities (NJ CDD) functions in accordance with the federal Developmental Disabilities Assistance and Bill of Rights Act, and in NJ State government by N.J.S.A. 30:1AA 1.2 and is codified in Title 10 of the State Administrative Codes. According to State statute the Title V agency has a seat on the NJ CDD. The purpose of the NJ CDD is to engage in advocacy, capacity building, and systemic change that contribute to a coordinated, consumer and family-centered, consumer and family-directed comprehensive system that includes needed community services, individualized supports, and other forms of assistance that promote self-determination for individuals with developmental disabilities and their families.

In accordance with the 1993 Family Support Act the NJ CDD established the Regional Family Support Planning Councils (RFSPCs) to provide a way for parents and family members of people with developmental disabilities to come together to exchange knowledge and information about family support services and to advocate for families and individuals with developmental disabilities at the local and state level on issues that directly impact their lives. They also collaborate with the state Division of Developmental Disabilities (DDD) on how to better serve individuals and their families.

The Medical Assistance Advisory Committee (MAAC) operates pursuant to 42 CFR 446.10 of the Social Security Act. The 15-member Committee is comprised of governmental, advocacy, and family representatives and is responsible for analyzing and developing programs of medical care and coordination. State SCHEIS staffs participate at MAAC meetings and share information on access to care through Medicaid managed care with Committee members as well as with SCHEIS programs. Likewise, information shared by the MAAC is incorporated into SCHEIS program planning to better assure coordination of resources, services, and supports for CYSHCN across systems. The quarterly MAAC meetings continue to provide a public forum for the discussion of systems changes in DHS's Medicaid program as well as invite collaboration across State programs. Updates keep stakeholders including the public and providers informed of NJ's progress in implementation of MLTSS, and the restructuring of services to children and youth with the developmental disabilities through DDD, DCF, DOE and DOL, Vocational Rehabilitation.

The Statewide Parent Advocacy Network (SPAN) and the NJ-AAP are key partners with the Title V Program in NJ in many initiatives and projects to better serve CYSHCN and empower families. The Statewide Community of Care Consortium, a leadership group of SPAN, dedicated to improving NJ's performance on the six core outcomes for CYSHCN and their families, includes three co-conveners from Title V, SPAN and AAP. This group also includes DHS, DCF, the NJ Primary Care Association, and over 60 statewide participating stakeholder organizations. The Community of Care Consortium partners are continuing to work to improve the access of children with mental health challenges to needed care, and to improve the capacity of primary care providers to address mental health issues within their practice. A

Family Guide to Integrating Mental Health and Pediatric Primary Care has been developed and shared with families. Community of Care co-conveners continue to meet with NJ's child protection agency, DCF Division of Protection and Child Permanency, about addressing challenges for children with mental health needs under their care. As an organization consisting of parents or families of CYSHCN, SPAN's guides, publications and presentations are consistently developed, by design, with family and consumer involvement.

Collaboration with the Department of Labor and Workforce Development ensures access to programs such as Vocational Rehabilitation, Social Security Disability Determination, Temporary Disability Insurance, and Workers Compensation. The Division of Vocational Rehabilitation (DVR) Services is responsible for training and placement of persons of employable age with disabilities. As SCHEIS counsels families on transition to adulthood planning options, programs regularly refer to DVR. Likewise, DVR staffs collaborate with SCHEIS programs on family and provider training, individual service plan, and individualized education plan development.

Childcare is a need for CYSHCN, and SCHEIS collaborates with MAPS to Inclusive Child Care Training and Technical Assistance Project, Healthy Start programs (all have Parent/Consumer Advisory Boards), as well as the MCCH Adolescent Health unit. The goals of the project are to increase the quality of early care and education for children with special needs; increase the number of child care providers that offer inclusive child care; increase awareness among parents, child care providers ,and child care resource and referral agencies of the services available for children with special needs; and improve the delivery of services for children with special needs through collaboration among providers of child care services and special needs services. Its focus remains planning to develop strategies that facilitate and enhance the inclusion of CYSHCN in child care settings.

Title V works with many different partners to help ensure NJ is on the cutting edge with newborn screening policies and operations in NJ. The Newborn Screening Advisory Review Committee (NSARC), established by Executive Order from the Commissioner includes parents, primary care physicians, specialists, nurses, health care organization representatives, including those from Medicaid and private health plans, advocacy organizations, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the Centers for Disease Control.

SCHEIS works with many federal partners and other state/territory colleagues to share and gain information on services and initiatives for CYSHCN. In March and May of 2015, SCHEIS participated in technical assistance calls arranged through HRSA's MCHB to share information on NJ's critical congenital heart defects screening program and the autism registry respectively. In May 2012, NJ was one of six states to receive a 3-year HRSA-funded implementation grant for pulse oximetry screening to detect critical congenital heart disease (CCHD). NJ was the first state in the nation to implement mandatory screening, and a number of infants have been detected through this screening that might otherwise have been discharged from the hospital without detection. Implementation of screening has been a collaborative effort with representation from the NJ Chapter AAP and SPAN on the NJDOH CCHD Screening Working Group. In addition, the grant has enabled us to expand our educational and training efforts throughout the state with a subgrant to the AAP, NJ Chapter.

School health coordination and collaboration is accomplished statewide through funding to three regional CSH grantee agencies, each with a seven-county service area. Through a mini-grant opportunity developed in SFY2014 and implemented in SFY2015, the CSH regional grantees and Adolescent Health State staff worked with various advisory "experts" from state government or professional statewide organizations to develop (SFY 2014) and implement (SFY2015) a mini-grant application in each of the Coordinated School Health model components. Parental involvement is a key element of the CSH program. Parent led Councils provide input to the program and participate in the implementation.

The NJ Statewide Network for Cultural Competence began in 2002 as an initiative of the NJ DOH FHS Title V program to improve culturally competent policies, procedures and practices through participation in a technical assistance project developed by the National Center for Cultural Competence at Georgetown University. Upon completion of the project, participants decided to work together to develop a broad-

based network to advance culturally competent practices in NJ. Early milestones included the development of a listserv and resource directory in 2003, and the launch of a website in 2005. The NJSNCC has held four (4) statewide annual conferences in 2010, 2012, 2014 and 2015, and is in the process of planning for another one in the Fall of 2016. The Network initiated the first of its webinars last year, and plans to hold webinars on a quarterly basis.

The agencies and organizations involved in the Network include more than 130 public/non-profit State, community and private sector agencies engaged in or promoting culturally and linguistically competent service delivery, education, policies and practices. The goals are to: identify existing resources in NJ; i.e. agencies and individuals who have knowledge and skills working with people from diverse needs, cultures, languages or population groups; foster professional development and education; stimulate, promote and celebrate the development and dissemination of best and promising practices in culturally and linguistically competent service delivery. Objectives are to promote knowledge, dissemination, exchange and application of culturally and linguistically competent practices; demonstrate that such practices increase access; improve quality of care, services, and outcomes; reduce disparities and foster health equity; share policy and practice guidelines in culturally and linguistically competent service delivery; collect, compile and share resource information on programs and services that are culturally and linguistically competent; provide a statewide resource tool/guide for accessing culturally and linguistically competent services to individuals and families with diverse needs; and, identify key stakeholders and constituencies and opportunities for affiliations and future collaborative activities.

As evidenced by the multitude of advisory council, consumer groups, coalitions, interdepartmental work groups, and committees, the NJDOH places a great emphasis on the active and meaningful participation of parents and consumers in the development, design and implementation and evaluation of Title V programs. This is a core strength of the NJDOH Title V programs.

II.F.4. Health Reform

National health care reform has been one of many changes impacting the role of FHS as NJs Title V agency. FHS has positioned itself to play an important role in health systems development and transformation. FHS had long ago shifted from a direct service delivery orientation to a preventive, population-based assurance role that could be responsive to new national programs and policies and the changing economic climate.

The Affordable Care Act has significantly reduced barriers to accessing care for residents of NJ. MCH grantees, stakeholders and partners typically refer uninsured pregnant women, women of childbearing age, children and adolescents to resources to access primary, preventive and reproductive health care services. While there is no way to identify the exact number of residents who the MCH Block Grant serves that have gained insurance coverage as a result of the Affordable Care Act and Medicaid expansion, it is clear that the collective work of MCH grantees, stakeholders and partners has yielded great returns when we examine NJ's overall insurance and Medicaid enrollment estimates since the implementation of the Affordable Care Act.

NJ's uninsured rate was reduced from 14.9% in 2013 to 11.7% in 2014. Over 250,000 residents signed up for commercial coverage through the Health Insurance Marketplace. More than one-third of those individuals were under the age of 35, which covers the age range for most childbearing women and children. As for Medicaid expansion, NJ has increased Medicaid enrollment by over 35% (458,489 more enrollees) as compared to averages from July - September of 2013. This is higher than the national average of 21% for the same timeframe.

Although the Affordable Care Act has clearly made a difference relative to access to care for a large number of residents of NJ, there are populations that have not directly benefitted from the law. Most notable among this population is undocumented residents. However, NJ does have programs that meet the needs of this at risk population. Through the State funded Uncompensated Care Fund, NJ reimburses 20 licensed federally qualified health centers with over 110 sites throughout the State (covering all 21 counties) for medical and dental care services provided to the uninsured. Among this population are women who would otherwise receive coverage for prenatal care services through a Medicaid Waiver program for pregnant undocumented women. The Medicaid waiver program has limited funds and once its funds have been exhausted, the population is automatically referred to the federally qualified health centers for necessary services. Through these collective efforts, MCH grantees, stakeholders, partners and other State Executive Branch agencies have had an impact on meeting the ongoing needs of MCH populations that remain uninsured despite the implementation of the Affordable Care Act.

As evidence of NJ's strong partnership with HRSA and the MCH Bureau, the State has consistently provided funding for the Uncompensated Care Fund. Last year, the State appropriated more than $28 million for this program. This allowed the federally qualified health centers to provide medical and dental services to over 96,000 uninsured women in 2015. The centers provided over 45,500 visits for reproductive health services to uninsured women that year. It also allowed the Centers to serve over 20,600 uninsured children ages 0-18, providing these children with needed medical and dental services.

In NJ, health care is beginning the transition to move out of hospitals and into outpatient settings through the Accountable Care Organizations and the new Delivery System Reform Incentive Payment Program. The NJ DOH has allocated $166.6 million in hospital funding, approved by the Centers for Medicare and Medicaid Services, to the Delivery System Reform Incentive Payment (DSRIP) program. The DSRIP Program is one component of the NJ's Comprehensive Medicaid Waiver as approved by the Centers for Medicare & Medicaid Services (CMS). DSRIP is a demonstration program designed to result in better care for individuals (including access to care, quality of care, health outcomes), better health for the population, and lower costs by transitioning hospital funding to a model where payment is contingent on achieving health improvement goals. Hospitals may qualify to receive incentive payments for implementing quality initiatives within their community and achieving measurable, incremental clinical outcome results demonstrating the initiatives' impact on improving the NJ health care system.

The DSRIP program supports the Healthy NJ 2020 vision: "For New Jersey to be a state in which all people live long, healthy lives." This innovative program will reward hospitals with funding to improve quality of care by facilitating and providing home bound services, improved hospital services and reducing the number of re-hospitalizations for the conditions the participating hospitals have chosen to address. These conditions include obesity, diabetes, asthma, cardiac care, chemical addiction and behavioral health. FHS/Title V staffs have been collaborating with the NJDOH/DSRIP staffs and Department of Human Services /Division of Medical Assistance and Health Services (Medicaid) in the design and implementation of the program to assure that MCH population needs are addressed.

FHS staffs and grantees also have been working in collaboration with the NJ Department of Human Services /Division of Medical Assistance and Health Services as they reviewed and certified three Accountable Care Organizations (ACOs) for the cities of Newark, Trenton and Camden.

The Healthy Greater Newark ACO will serve three zip codes within the city of Newark where the need for health care services is high. These zip code areas have been found to have a significant number of people who experience higher rates of emergency room visits and a greater rate of hospital admissions than those living in other parts of the city. Not only will the ACO improve access to care, it will provide supportive services to people in their homes and in the community. This will have a significant impact in reducing unnecessary hospitalizations and emergency room visits that place enormous burdens on the patients themselves and the area hospitals.

The Healthy Greater Newark ACO as part of their needs assessment findings will focus on improving care for chronically ill children, as well as enhancing perinatal and maternal health services. FHS is utilizing this opportunity to help strengthen availability and access to primary care for the families and children we serve by joining in a coordinated effort to provide quality care primarily in high need areas such as the city of Newark.

Trenton Health Team (THT) and the Camden Coalition of Health Care Providers were also approved by the State to form a Medicaid Accountable Care Organization (ACO) to serve the Trenton and Camden community as part of a three-year demonstration project utilizing a three-part goal of improving health outcomes, lowering healthcare cost and improving the patient's experience of receiving care. THT's and the Camden Coalition Medicaid ACO will achieve those goals through continuing and expanding upon collaborating with the community at large, health and social services organization and the Departments of Health, Human Services and Children and Families. FHS will continue to collaborate with these three ACOs to ensure that our MCH population needs are being addressed.

II.F.5. Emerging Issues

Emerging MCH Issues have been included in the State Action Plan narrative and include Obesity, Nutrition, Autism and Improving and Integrating Information Systems. These issues have been considered emerging issues for several years and their importance recognized by State Priority Needs (#2 Improving Nutrition & Physical Activity and #7 Improving & Integrating Information Systems) and State Performance Measures (#5 Age of Reporting Autism to the BDARS).

II.F.6. Public Input

An integral part of the NJDOH's efforts to secure public input into the annual development of the MCH Block Grant Application and Annual Report, a public hearing is scheduled each year. A draft of the application narrative is posted on the NJDOH's website four weeks prior to the public hearing. Notification of the public hearing and availability of the draft application is posted on the NJDOH's website and is e-mailed to over 300 individuals on the Division of Family Health Services e-mail distribution lists.

The Maternal and Child Health Block 2015 Grant Public Hearing was held on June 23, 2015 from 9:30AM to 12:00PM at the New Jersey State House Annex Committee Room 1. Dr. Gloria Rodriguez, Assistant Commissioner, Division of Family Health Services, Dr. Marilyn Gorney-Daley, Director of Special Child Health and Early Intervention Services, and Ms. Pauline Lisciotto, Program Manager for Family Centered Care Services presided over the hearing as Panel Members. There were 10 scheduled presenters which included professionals and many families. One mother, who was not scheduled, was able to present as well. All testimonies given were in strong support of Title V resources and services. Concerns regarding New Jersey's high prevalence rate for autism and the high demand for child evaluation services were expressed. The value, need and interest in continued and enhanced partnerships with organizations including the Boggs Center and the Statewide Parent Advocacy Network (SPAN) was also stressed in several of the testimonies.

Many families, especially those with children with special health care needs, described the critical value of peer to peer connections, afforded through Title V resources. The value of family resource specialists and case managers who work directly, and in person, with families was highlighted. The work of Title V to reduce health disparities and ensure cultural competence was also stressed. Dr. Rodriguez and panel members expressed sincere appreciation to the attendees and presenters for their testimony and input. Overall, testimony was most positive and the need to continue efforts and work of Title V toward improved outcomes for NJ's children and families was stressed. In addition to public testimony five written letters in support of the MCH Block Grant application were received by FHS.

Input into Title V activities is encouraged throughout the year through involvement of individuals and families in the many advisory groups and task forces as described in Sections II.B.2.c. and II.F.3.

SPAN submitted extensive input into the development of the MCH Block Grant application and feedback on the Five Year Needs Assessment. Included as Supporting Document #4 in the MCH Block Grant Application/Annual Report is a letter from SPAN that includes comments regarding the 2016 application that SPAN presented during the public hearing on June 23, 2015.

SPAN is NJ's federally designated Parent Training and Information Center, RSA (Rehabilitation Services Administration) Transition Parent Information and Training Center, and Family to Family Health Information Center, as well as the NJ State Affiliate Organization for National Family Voices, which works to "keep families at the center of children's healthcare," and NJ chapter of the Federation of Families for Children's Mental Health. SPAN has over 25 years of work reaching, supporting, and engaging diverse families in advocacy on behalf of their children and families as well as in systems improvement activities across the Maternal and Child Health priority areas.

SPAN has been involved in collaborations with NJDOH/FHS on various projects such as Family WRAP (Wisdom, Resources, and Parent to Parent), EHDI (Early Hearing Detection and Intervention), Coordinated School Health, Essex Improving Pregnancy Outcomes, Partners for Prevention of Birth Defects & Developmental Disabilities, Effective Health Promotion Communication with Diverse Women of Childbearing Age, Infant Mortality CoIIN (Collaborative Improvement & Innovation Network), MIEC Home Visiting programs, Superstorm Sandy Resiliency Project, the Community of Care Consortium (COCC), and the Coordinated School Health Parent Leadership Development Initiative. Some other programs of great value include County Special Child Health Services Case Management Units, early childhood obesity prevention, lead poisoning prevention, Traumatic Loss county coalitions, Family-centered Care HIV Network, Child Evaluation Clinics, and Newborn screening/Birth Defects and Autism Registry.

SPAN has held focus groups with diverse families and collected over 500 surveys of families and professionals regarding state priority needs and effectiveness of currently-funded programs and shared that information with the NJDOH to feed into the MCH block grant development process. SPAN also provides monthly family vignettes on how parents are assisted with systemic issues.

SPAN conducted an online survey relating to the 2015 Five Year Needs Assessment, which included 418 parents of children under age 21 (196 parents of children with special needs, 52 parents of children without special needs, and 170 parents of children with and without special needs) and 108 professionals. The age of respondents ranged from 18-24, to over 65, with 2/3 of respondents aged 35-54. 46.1% of respondents were Caucasian, 18/9% were African-American, 20% were Latino, 8% were Asian, and 7% were Other.

Respondents had experience with a wide variety of MCH Title V initiatives, with 85.2% having experience with SPAN Family Resource Specialists; 55.9% having experience with NJ Statewide Parent to Parent; and 24.2% having experience with Family Voices. 45.8% had experience with county SCHS Case Management Units; 33% had experience with the Newborn Screening program and registry; 29.2% had experience with the lead poisoning prevention initiatives; 27% had experience with home visiting programs; 25% had experience with programs to improve birth outcomes and prevent birth defects; 13% had experience with Coordinated School Health; 12% had experience with Shaping NJ Early Childhood Obesity Prevention; and 10.2% had experience with the Family Centered HIV Network.

There was strong support among respondents for all of the state's identified priority needs, with at least 70% of respondents agreeing with each of the State's selected priority needs. The strongest support was for SPN #5 Increasing access to quality care for CYSHCN (93%), followed by SPN #1 Increasing Healthy Births (86%), SPN #2 Improving Nutrition and Physical Activity (84%), and Promoting Adolescent Development (81.4%). SPAN noted that 70% of respondents felt that reducing hospitalizations due to asthma was a high priority area for continued focus.

Specific suggestions for additional state priorities included recommendations concerning mental health, autism and developmental disabilities, early childhood, education, improving birth outcomes, health promotion, health insurance/health coverage, health access/disparities, transition-related recommendations and other areas. Recommendations regarding mental health included addressing the difficulty in finding trained professionals for children and adolescents and the need for help for parents with mental health, drug and alcohol problems. Challenges in finding quality mental health services for children with special health care needs were stressed. The mental health system as a whole had many issues/problems including a lack of advocacy and cost issues for quality services.

SPAN represents a family voice on most of the Title V Advisory Committees/Task Forces/Work groups, including among others:

- Newborn Screening and Genetic Services advisory panel
- CCHD Screening Working Group
- Infant Mortality CoIIN
- NGA Improving Birth Outcomes Task Force (Data, Payment Strategies, and Wellness workgroups)
- Home Visiting Workgroup

- Infant Child Health Committee
- Help Me Grow Leadership Team
- Shaping NJ

SPAN has been invited to join the reorganized Technical Advisory Group for the Public Health Tracking Project of the NJ State Health Assessment Data website, and note that the website is an easy to use treasure trove of health data critical to understanding the health of NJ residents and identifying areas of focus for program implementation and policy advocacy.

In addition, SPAN facilitated Advisory Committees/Task Forces/Work Groups for the NJ Department of Health including the Community of Care Consortium for CYSHCN and its workgroups on Early and Continuous Screening; Medical Home & Community-Based Services; Adequate Health Financing; and Transition to Adult Systems of Care, each of which is co-chaired by a parent leader and a professional to ensure integration of Family Engagement at All Levels and Satisfaction with Services; Partners for Prevention of Birth Defects and Developmental Disabilities; and the Stakeholder Advisory Committee for our county Improving Pregnancy Outcomes Initiative project.

Further, SPAN has engaged families involved in all of its projects, from the IPO Initiative projects (maternal/women's health and prenatal/infant health), Family to Family Health Information Center (child health, adolescent health, CSHCN), Transition to Adult Life projects (adolescent health, CSHCN), and myriad of projects focused on CSHCN, in reviewing and providing input on the state's current activities and priorities. SPAN's MCH Block Grant comments focus on all of the targeted priority areas. Thus, SPAN at least is directly involved in MCH Block Grant development and review, materials development, and advocacy across all of the domains.

SPAN has taken the model of Family Resource Specialists, trained parents of CSHCN from a wide variety of backgrounds speaking 11 languages, and housed at county SCHS Case Management Units, to other arenas and locations, including CNNH, FSOs, and FQHCs, with funding from other sources such as the Parent Training and Information Project and the three State Implementation Grants (ISG I-III) from the US Department of Health and Human Services.

After the conclusion of the ISG III Innovative Evidence-Based Program for Immigrant Families Served by FQHCs focused on 3 FQHCs in three high-immigrant communities, WellCare provided funding to sustain the bilingual Family Resource Specialist at the Elizabeth FQHC. The FRS (a) provided training on rights/laws, parent-professional collaboration and advocacy strategies, resources, and parenting and health promotion practices; (b) supported the professionals at the FQHC to help them improve their capacity to partner with and effectively serve parents of children with special needs including developing stronger relationships with agencies and providers focused on children with special needs; and (c) provided intensive support to a subsection of the families who demonstrated a need for that intensive support.

SPAN, as a family advocacy organization, is also involved in Workforce Development in the area of child health via our Coordinated School Health Parent Leadership Development Project and training of the other CSH grantees on engaging and working with families. SPAN and three other grantees work closely with the CSH program manager on strategic and program planning and quality improvement for the CSH initiative.

Through inclusion of the public in the development of the Application/Annual Report and the hosting of public hearings, through which the general public has the opportunity to give input to the NJDOH relative to the MCH Block Grant Application/Annual Report, New Jersey consistently is positioned to deliver the most appropriate and responsive MCH services to residents. Key to any success we achieve is the integration of specific priorities raised by diverse populations that NJDOH serves.

II.F.7. Technical Assistance

FHS has identified the need for technical assistance in the area of MCH workforce professional development and will complete and submit a Technical Assistance Request Form.

III. BUDGET NARRATIVE

III.A. Expenditures

Annual expenditures are summarized in below. The State Title V Programs Budget and Expenditures by Types of Service, parallels the MCH pyramid which organizes MCH Services hierarchically from direct health care services through infrastructure building services.

III.B. Budget

New Jersey has traditionally maintained commitment of State funding support for maternal and child health activities. Since 1989, maintenance of effort has included State appropriations for children with special health care needs and support for population-based outreach and education for pregnant women and their infants.

State appropriations support a number of maternal and child health programs. In the State fiscal year 2015 budget most programs and services are maintained at the SFY 2014 levels. Due to the continuing state fiscal crisis, the proposed SFY 2015 budget includes reductions in a few service areas including postpartum depression education and the elimination of state funding for family planning. However, based on the critical nature of the budget deficit in the state the proposed budget demonstrates an ongoing commitment on the part of the State to support to the best of its ability services to the maternal and child health population. The following are the funding levels for programs and services for FFY 2015 that reach maternal and child health populations in New Jersey:

Funding Levels for Programs and Services	SFY 2015
Birth Defects Registry	$ 564,000
Cleft lip and palate projects	$ 690,000
Infant mortality reduction	$ 2,000,000
Sudden Infant Death Syndrome	$ 221,000
Newborn screening	$ 4,778,000
Postpartum Depression screening and referral	$ 1,900,000
Early Intervention for developmental delay/disabilities	$ 85,973,000
Childhood lead poisoning prevention	$ 985,000
Hemophilia services	$ 1,245,000
Catastrophic illness in children relief fund	$ 1,700,000
Handicapped children's fund, which is used to support subspecialty care and case management services	$ 2,500,000
Fetal Alcohol Syndrome	$ 570,000
MCH Services	$ 5,500,000
Council Physical Fitness and Sports	$ 50,000
Autism Registry	$ 750,000

All of the funding sources are considered in the programmatic narrative portion of this application. There have been few variations in the allocation and expenditure of the federal/state partnership funds for maternal and child health over the last few years. This year state appropriations do not include cost of living increases and reductions are evident in a few areas including family planning and early intervention.

Table 1a: New Jersey Five-Year Needs Assessment Framework Logic Model – Listed by NPM

Domains *(set by HRSA)*	***State Priority Needs*** *based on Needs Assessment*	***Strategies*** *(to be developed into Evidence-Based Informed Strategy Measures (ESMs) for 2017)*	***National Outcome Measures (NOMs)*** *(states select from list)*	***National Performance Measures (NPMs) &*** *State Performance Measures (SPMs)*	***Evidence-Based Informed Strategy Measures (ESMs) DRAFT***
1) Women's/ Maternal Health	#1 Increasing Healthy Births	Improving Pregnancy Outcomes (IPO) Initiative; Central Intake (CI) & Community Health Workers (CHW) IM CoIIN; MIEC Home Visiting Program (MIECHV); Office of Women's Health; Perinatal Designation Level regulations, Development of the NJ VON Collaborative, MCH Consortia TQI Activities	1 Prenatal Care; 2 Maternal Morbidity; 3 Maternal Mortality; 4 Low Birth Weight; 5 & 6 Preterm Births 8 Perinatal Mortality; 9 Infant Mortality; 10 FAS; 11 NAS	**NPM #1 Well Women Care** (Percent of women with a past year preventive medical visit)	Increase first trimester prenatal care (EBC) from birth certificate records (VIP)
2) Perinatal/ Infant Health	#3 Reducing Black Infant Mortality	Improving Pregnancy Outcomes (IPO) Initiative; IM CoIIN; MIEC Home Visiting Program; NJ SIDS Center activities; Healthy Start; HBWW, SUID-CR; DOSE; Tote Bags Surveillance (PRAMS, EBC)	1, 2, 3, 4, 5, 8, 9 9.5 Sleep Related SUID; 15 Child Mortality; 19 Child Health Status	**NPM #5 Infant Safe Sleep** (Percent of infants placed to sleep on their backs) SPM #1 Black preterm births	1) Increase infant safe sleep (PRAMS -back, no co-sleeping, no clutter) 2) Decrease unsafe infant sleep related deaths (SUID-CR)
2) Perinatal/ Infant Health	#3 Reducing Black Infant Mortality	Improving Pregnancy Outcomes (IPO) Initiative; IM CoIIN; MIEC Home Visiting Program; Healthy Start; HBWW, Loving Support© Through Peer Counseling Breastfeeding Program Baby Friendly Hospitals, BF Surveillance (PRAMS, EBC) Breastfeeding and NJ Maternity Hospitals: A Comparative Report	1, 4, 5, 8, 9, 9.5, 10, 11, 15, 19	**NPM #4 Breastfeeding** (A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months) SPM #1 Black preterm births	1) Increase births in Baby Friendly hospitals (EBC/mPINC)

Domains *(set by HRSA)*	***State Priority Needs*** *based on Needs Assessment*	***Strategies*** *(to be developed into Evidence-Based Informed Strategy Measures (ESMs) for 2017)*	***National Outcome Measures (NOMs)*** *(states select from list)*	***National Performance Measures (NPMs) &*** *State Performance Measures (SPMs)*	***Evidence-Based Informed Strategy Measures (ESMs)***
3) Child Health	#2 Improving Nutrition & Physical Activity	ShapingNJ; Whole School, Whole Community, Whole Child (WSCC); NJ AHPERD; Healthy Community grants; Obesity efforts in Nemours Foundation collaboratives; Early care and education NPA Sustainable Jersey for Schools certification; YMCA State Alliance	14 Cavities; 19 Child Health Status; 20 Overweight	**NPM #8 Physical activity** (Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day) SPM #2 Elevated blood lead screenings;	
3) Child Health	#4 Promoting Youth Development	Early Intervention System MIECHV Project LAUNCH and Help Me Grow with DCF ECCS Impact with DCF NJ AAP/PCORE Medical Home Project	13 School Readiness; 17 CSHCN; 18 Mental/Behavioral 19 Child Health Status;	**NPM #6 Developmental Screening** (Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool)	1) Increase completed ASQ developmental screens online as part of ECCS Impact Program
4) Adolescent/ Young Adult Health	#4 Promoting Youth Development	NJ AAP/PCORE Medical Home Project; Outreach to providers; Case Management Services;	16.1 Adolescent Mortality; 16.2 MVA; 16.3 Suicide; 17, 18, 19, 20, 21,22	**NPM #10 Adolescent Medical Visit** (Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year)	
4) Adolescent/ Young Adult Health and 5) CYSHCN	#4 Promoting Youth Development, #6 Reducing Teen Pregnancy	NJ AAP/PCORE Medical Home Project; Transition to adulthood needs assessment; SPAN/ISG 1; ARC of NJ	16.1 Adolescent Mortality; 16.2 MVA; 16.3 Suicide; 19 Child Health Status 17, 18, 19, 20, 21,22	**NPM #11 Medical Home** (Percent of children with and without special health care needs having a medical home)	

Domains *(set by HRSA)*	***State Priority Needs*** *based on Needs Assessment*	***Strategies*** *(to be developed into Evidence-Based Informed Strategy Measures (ESMs) for 2017)*	***National Outcome Measures (NOMs)*** *(states select from list)*	***National Performance Measures (NPMs) &*** *State Performance Measures (SPMs)*	***Evidence-Based Informed Strategy Measures (ESMs)***
5) CYSHCN and 4) Adolescent/ Young Adult Health	#5 Improving Access to Quality Care for CYSHCN	Case Management Services; NJ AAP/PCORE Medical Home Project; Outreach to providers; Hospital level reports; Audits; Provider education CM level reports; Medicaid Managed Care Alliances, Subsidized Direct Specialty and Subspecialty Services, Participation in Medical Assistance Advisory Council, Arc of NJ	19 Child Health Status 16, 17, 18, 19, 20, 21,22	**NPM #12 Transitioning to Adulthood** (Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care) SPM #3 Hearing screening F/U; SPM #4 Referred from BDARS to Case Management Unit; SPM #5 Age reporting autism to BDARS;	
6) Life Course		Project REACH, Project PEDS ShapingNJ; MIEC Home Visiting; Dial a Smile Dental Clinic Directory; Miles of Smiles; WIC Newsletter; Special Needs Newsletter;	14 Kids 1-6 with cavities; 19 Child Health Status;	**NPM #13 Oral health** (A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year)	1) Preventive and any dental services for children enrolled in Medicaid or CHIP (CMS-416)
6) Life Course	#7 Improving & Integrating Information Systems	IPO, Central Intake / PRA MIEC Home Visiting SSDI, ECCS; VIP; Master Client Index Project	Most NOMs	Most NPMs	
6) Life Course	#8 Smoking Prevention	SSDI, ECCS Mom's Quit Connection; Perinatal Addiction Prevention Project; IPO, Central Intake / PRA MIEC Home Visiting	Most NOMs	**#14 Household Smoking** (A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes)	1) Increase referrals of pregnant women to Mom's Quit Connection

Table 1b: Findings of the Five-Year State Needs Assessment *(from Appendix B, Guidance page 9)*

Domains	***State Priority Needs***	***Title V Capacity*** *(*strengths*/needs)* *(*adequacy*/limitations)*	***Title V Partnerships*** *Family/consumer engagement, Leadership, Coordination*	***Health Status on Pertinent NPMs*** *and NOMs*
1) Maternal/ Women's Health	#1 Increasing Healthy Births	Improving Pregnancy Outcomes Initiative; Central Intake; CHW IM CoIIN; MIECHV; MCHCs; *InterDepartmental collaboration; Systems development; Involvement of health care providers, insurers and payors;*	IPO County Advisory Groups IM CoIIN Workgroups MIEC Home Visiting Advisory Groups	#1 Well Women Care ↔ Legend ↑ improving ↔ unchanged ↓ worsening
2) Perinatal/ Infant Health	#3 Reducing Black Infant Mortality	Improving Pregnancy Outcomes Initiative; Central Intake; CHW IM CoIIN; MIECHV; MCHCs; *InterDepartmental collaboration; Systems development; Involvement of health care providers, insurers and payors;*	IPO County Advisory Groups IM CoIIN Workgroups MIEC Home Visiting Advisory Groups	#4 Breastfeeding↑ #5 Safe Sleep ↑
3) Child Health	#2 Improving Nutrition & Physical Activity	ShapingNJ Coordinated School Health/Whole School, Whole Community, Whole Child (CSH/WSCC)	CSH/WSCC Partnerships ShapingNJ partnership YMCA State Alliance Sustainable Jersey for Schools	#8 Physical activity ↔
4) Adolescent/ Young Adult Health	#4 Promoting Youth Development, #6 Reducing Teen Pregnancy	Transition to adulthood needs assessment; SPAN/ISG 1; ARC of NJ NJAHIVSTDPPCC	NJ Adolescent HIV STD & Pregnancy Prevention Collaborating Coalition (NJAHIVSTDPPCC) Practice Parent Advisory Council	#11 Medical Home ↔ #12 Transition to Adulthood ↔
5) CYSHCN	#5 Improving Access to Quality Care for CYSHCN	21 SCHS Case Management Units SPSP Services (9 CECs with 4 FAS, 5 Cleft Lip/Palate, 3 Tertiary Care); regionalized NJ Family WRAP (family support); 7 RWPD Family Centered HIV Network; NJ AAP/PCORE Medical Home Project; Superstorm Sandy Block Grant enhanced capacity for SCHS Case Management,	Family Satisfaction Surveys Intergovernmental collaboration with Social Security Administration and State agencies; DHS Medicaid /NJ FamilyCare, Division of Disability Services, Division of Developmental Disabilities; DCF's Children's System of Care Initiative, Perform Care, DOBI Division of Insurance; DOL Disability Determinations Unit; DOE Part B Community of Care Consortium &	#11 Medical Home ↔ #12 Transition to Adulthood ↔

		Family WRAP, Medical Home but funding ends 6/30/15 and families and medical home initiatives need to transition	Special Education Advisory Taskforce; DOH Public Health Service, Health Systems, Public Health Infrastructure, Laboratories, & Emergency Preparedness; Catastrophic Illness in Children Relief Fund, NJ Council on Developmental Disabilities, Special Education Advisory Council; SPAN, Community of Care Consortium (COCC); Map to Inclusive Childcare Team; NJ Inclusive Childcare Project	
6) Life Course	#7 Improving & Integrating Information Systems, #8 Smoking Prevention	Mom's Quit Connection; Perinatal Addiction Prevention Project; Central Intake / PRA; *Involvement of health care providers, insurers and payors;*	MCHC; NJ Medical Society; NJ-AAP	#13 Oral Health ↑ #15 Household Smoking ↑

Table 1c - Summary of MCH Population Needs

Domains	**State Priority Needs**	**Pertinent NPMs** (trend - ↑ improving, ↔ unchanged, ↓ worsening)	**+ Strengths / - *Needs***	**Successes, *challenges, gaps, disparities* (major health issues)**
1) Maternal/ Women's Health	#1 Increasing Healthy Births	#1 Well Women Care↔	+Low uninsured rates, *-Low preventive care use*, *-Late prenatal care, -Unintended pregnancy*	Multiple initiatives, *Lack of preventive care, Late/inadequate prenatal care, Unintended pregnancy*
2) Perinatal/ Infant Health	#3 Reducing Black Infant Mortality	#4 Breastfeeding ↑ #5 Safe Sleep↑	+Baby Friendly Initiative +Revised Hospital regulations, +Strong coalitions, +SUID-CR	Baby Friendly Initiative *Formula supplementation, Unsafe sleep practices*
3) Child Health	#2 Improving Nutrition & Physical Activity	#8 Physical Activity ↔ #6 Developmental Screening ↑	+ShapingNJ partnerships, +CSH/WSCC regional partnerships, *-funding*	ShapingNJ partnerships *Built environment caloric dense foods lack of PA opportunities*
4) Adolescent/Young Adult Health	#4 Promoting Youth Development, #6 Reducing Teen Pregnancy	#11 Medical Home↔, #12 Transitioning to Adulthood↔	+Advocacy groups - SPAN +HIV/STD/TPP Coalition, *-funding*	*Lack of preventive care, barriers to sharing medical information*
5) CYSHCN	#5 Improving Access to Quality Care for CYSHCN	#11 Medical Home↔, #12 Transitioning to Adulthood↔ #10 Adolescent Well Visit↑	+Advocacy groups, *-funding -TA*	*Health insurance reimbursement*
6) Life Course	#7 Improving & Integrating Information Systems, #8 Smoking Prevention	#13 Oral Health↑, #15 Household Smoking↑	+Cessation options *-Lack of provider participation*	*Health insurance reimbursement, Smoking relapse*

Table 1d – Title V Program Capacity and Collaboration to Ensure a Statewide System of Services

Domain	State Priority Needs (SPNs)	Collaborations with other state agencies and private organizations	State Support for Communities	Coordination with Community-Based Systems	Coordination of Health Services with other Services at the Community Level
1) Maternal/ Women's Health	#1 Increasing Healthy Births	IPO with DCF, MCHC, IM CoIIN with DHS	IPO Advisory Groups & CI Hubs	IPO with Central Intake and CHWs, MCHC	Central Intake with DCF, MIECHV, Healthy Start, Strong Start, WIC
2) Perinatal/ Infant Health	#3 Reducing Black Infant Mortality	MCHC, Home Visiting with DCF & DHS, NJHA Perinatal Collaborative, IM CoIIN with DHS	IPO Advisory Groups & CI Hubs	IPO with Central Intake and CHWs, MCHC	Central Intake with DCF, MIECHV, Healthy Start, Strong Start, WIC
3) Child Health	#2 Improving Nutrition & Physical Activity	ShapingNJ, CSH/WSCC AHPERD, NJPHK, SOPHE, NJDA, DEP, JJC, DoT	CSH/WSCC grantees, NJ Council on Physical Fitness & Sports; OLHD; Chronic Disease Coalition	FQHCs CSH/WSCC	School Health, Early Care & Education
4) Adolescent/Young Adult Health	#4 Promoting Youth Development, #6 Reducing Teen Pregnancy	School Health with DOE, DCF PREP AEP NJAHIVSTDPPCC	PREP & AEP grantees; CSH/WSCC grantees	Adolescent Advisory Group; CSH/WSCC	
5) CYSHCN	#5 Improving Access to Quality Care for CYSHCN	NJ AAP/PCORE Medical Home, County Base Management	SCHS Case Management Units	County-based Case Management	EIS
6) Life Course	#7 Improving & Integrating Information Systems, #8 Smoking Prevention	IPO with DCF; HV with DCF & DHS; NJ Medical Society NJ-AAP; NJ OB/GYN Society MCHC	IPO Advisory Groups & CI Hubs	IPO with Central Intake and Community Health Workers	Central Intake with DCF

Table 1e - Staffing for MCHS

Staff Person	Title	Function	Related NPM	Tenure in MCH
Lisa Asare	Assistant Commissioner	MCH Title V Director	1-15	10
Nashon Hornsby			1-15	11
vacant	MCHS Director	Director of MCHS Services Unit	1-15	
Lakota Kruse	Medical Director	HV Program Director	1-15	23
vacant	RPHS Program Manager	Oversees RPHS	1-15	
Cynthia Collins	CAHS Program Manager	Oversees CAHS	7-12	23
Maggie Gray	Coordinator Primary & Preventive Health Services	Coordinator RPHS programs	1-6	19
Anna Preiss	Research Scientist 2	Coordinator MIECHV and RPHS programs	1-6	21
Renee Booze-Westcott	Program Specialist 3	Coordinator RPHS programs	1-6	22
Elizabeth Dahms	Public Health Consultant 1 Nursing	Coordinator RPHS programs	1-6	16
Jasmine Osol	Public Health Consultant 1 Nursing	Coordinator RPHS programs	1-6	6
Loletha Johnson	Public Health Consultant 1 Nursing	Coordinator RPHS programs	1-6	16
Gilo Thomas	Public Health Consultant 1 Nursing	PREP Coordinator	7-12	11
Crystal Owensby	Coordinator Primary & Preventive Health Services	Child Health (lead poisoning prevention) Coordinator	7-12	23
Jaydeep Nanavaty	Research Scientist 1	Child Health Surveillance Coordinator	7-12	16
Pat Hyland	Public Health Consultant 1 Nursing	Child Health nurse case manager	7-12	23
Beverly Kupiec-Sce	COHP Director	Directs COPH activities	13	30
Ingrid Morton	MCH Epi Program Manager	Manages MCH Epi programs	1-15	23
Sharon Smith	Research Scientist 2	PRAMS Coordinator	1-15	13

Table 1e - Staffing for SCHEIS

Staff Person	Title	Function	Related Priority NPM	Tenure in MCH
Marilyn Gorney-Daley, DO, MPH	Director SCHEIS	Service Unit Director, Director for CSHCN	11, 12	19 yrs
Diane DiGiovacchino	Administrative Assistant 3	Administrative support	11,12	28 yrs
Rita Belfiore	Secretarial Assistant 3	Secretarial support	11,12	28 yrs
Joy Rende, MSA, RNC, NE-BC, CPHM	Program Manager, Early Identification and Monitoring	Supervises activities of Early Identification and Monitoring Program (EIM)	11,12	<1 yr
Joseph Sweatlock, PhD, DABT	Research Scientist I	Responsible for data management for EIM	11,12	12 yrs
Kathryn Aveni, RNC, MPH	Research Scientist I	Supervises activities of Early Hearing and Detection Intervention	11,12	14 yrs
Mary Knapp, MSN, RN,	Coordinator Primary and Preventive Health Services	Coordinator NJ Birth Defects Registry	11,12	31 yrs
Linda Biando, MSN, RN	Public Health Consultant 1, Nursing	Provides follow up with medical professionals	11,12	26 yrs.
Nancy Schneider, MA, CCC-A, FAAA	Research Scientist 2	Audiologist, liaison to the audiology community	11,12	14 yrs
Zenaida Steinhauer, RN, BSN,MPA	Quality Assurance Specialist, Health Services, Nursing	Ensures that the information on each BDR registration is accurate and complete	11,12	15 yrs
Anthony Mosco, AA	Software Development Specialist Assistant	Technical assistance related to the Birth Defects and Autism Registry	11,12	8 yrs
Sandy Howell, PhD	Research Scientist 1	Coordinates the Autism Registry	11,12	8 yrs
Nancy Scotto Rosato, PhD	Research Scientist 2	Assists in the coordination of the Autism Registry	11,12	8 yrs
Nicole Moore	Principal Clerk Typist	Provides clerical support for Birth Defects and Autism Registry	11,12	16 yrs
Donna Williams	Head Clerk	Provides supervision of clerical staff for Birth Defects and Autism Registry	11,12	11 yrs
Tracey Justice	Principal Clerk Typist	Provides clerical support for Early Hearing Detection and Intervention	11,12	13 yrs
Mary Lou Colon	Secretarial Assistant 3	Provides clerical support for Program Manager of EIM	11,12	8 yrs
Raymia Geddes	Principal Clerk Typist	Provides clerical support for Birth Defects and Autism Registry	11,12	4 yrs
Pauline Lisciotto, MSN, RN	Program Manager	Administer FCCS Unit; SCHS Case Management & Family Support, Fee for Service, Specialized Pediatric Services program (SPSP), Ryan White Part D activities	11,12	23 yrs
Linda Barron	Public Health Consultant 2, Nursing	Public health nurse consultation re: SPSP programs and services, program officer for SPSP health services grants	11,12	22 mos

	Specialized Pediatric Services Program (SPSP)			
Felicia Walton, BA	Program Specialist 3	Public health consultation re: SCHS CM programs, family support, and Fee for Service program, program officer for SCHS CM health services grants	11,12	6 yrs
Stephanie Kneeshaw-Price, MS, PhD	Health Data Specialist 1	Lead SCHS CM and Superstorm Sandy data collection and analysis, administers SCHS CM electronic case management referral system	11,12	18 mos
Ellen Dufficy, M.Ed., RN	Public Health Consultant 1, Nursing Ryan White Part D	Public health nurse consultation re: Women, Infants, Children, and Youth (WICY) infected and/or affected by HIV/AIDS. Liaison between Title V MCH & CYSCHN programs and WICY population, providers, and systems development	11,12	21 yrs
Dawn Mergen	Quality Assurance Specialist Health Services Nursing		11,12	7 mos
Christopher Santin	Health Data Specialist 3		11,12	5 mos
Susan Agugliaro	Secretarial Assistant 3	Clerical support to Program Manager and maintains Fee for Service Letters of Agreement	11,12	29 yrs
Kenette Johnson, BS	Principal Clerk Typist	Clerical support to SCHS CM and SPSP programs	11,12	11 yrs
Claudia Pollet, MD, MPH	Health Science Specialist	Supervises and directs activities of Newborn Screening & Genetic Services	11,12	22 mos
Suzanne Canuso, MSN, RN	Public Health Consultant 1, Nursing	Oversees and evaluates programmatic activities of Newborn Screening and Hemophilia health service grants.	11,12	6 yrs
Diane Driver, MSN, RN	Public Health Consultant 2, Nursing	Manages health services grants for Newborn Screening Follow-up Services	11,12	18 mos
Suzanne Karabin, MS	Research Scientist 2	Prepares data reports, meeting agendas and minutes, updates protocols/checklists for follow up on abnormal screening results, works with software vendor, initiates and follows cases as needed.	11,12	14.5 yrs
Yvonne Miller Watkins, RNC, BSN, MAS	Quality Assurance Specialist, Health Services, Nursing	Prepares and provides training and quality improvement visits to NJ birthing hospitals, ensures quality of program charts, initiates and follows cases as needed.	11,12	14 yrs

Jon Watkins, MPA, CHES	Public Health Representative 1	Provides follow-up of all newborns with abnormal screening results	11,12	9 yrs
Karyn Dynak	Supervising Public Health Representative	Provides follow-up of all newborns with abnormal screening results	11,12	8 yrs
Felicidad Santos, MD, MPH	Public Health Representative 1	Provides follow-up of all newborns with abnormal screening results	11,12	7 yrs
Tariq Ahmad, MBBS, MPH	Public Health Representative 1	Provides follow-up of all newborns with abnormal screening results	11,12	8 yrs
Kathy Melnicki	Public Health Representative 1	Provides follow-up of all newborns with abnormal screening results	11,12	28 mos
Alvina Randolph	Head Clerk	Provides clerical support for Newborn Screening Follow-up	11,12	24 yrs
Paula Jumper	Principal Clerk Typist	Provides clerical support for Newborn Screening Follow-up	11,12	4 yrs
Betty Durham	Principal Clerk Typist	Provides clerical support for Newborn Screening Follow-up	11,12	15 yrs
Parents/Family members				
Statewide Parent Advocacy Network Diana Autin (grantee)	Executive Director	Parent Partner	11,12	21+

Table 1f - MCH Organizational Relationships with Partnerships, Collaboration, and Cross-Program Coordination

Domain	*State Priority Needs*	*MCHB Investment Grant*	*Other Investments*	*Other DOH*	*Other State Departments*	*Local Agencies*	*Performance Measures/ Goals*	*Family Consumer Partnerships*
1) Maternal/ Women's Health	#1 Increasing Healthy Births,	*MIECHV,*	*FQHC, Family Planning*	*HIV/AIDS; WIC; CH&W*	*DCF, DHS, DOE*	*IPO grantees, MCHC, MIECHV grantees*	*IPO objectives; HV Benchmarks; NPM 1,2,3; NOM 1-8,21,22*	*HV Advisory WG*
2) Perinatal/ Infant Health	#3 Reducing Black Infant Mortality,	*MIECHV, Healthy Start, SSDI*	*FQHC, WIC; SUID-CR*	*NJIIS; WIC*	*DCF, DHS, DOE*	*IPO grantees, MCHC, MIECHV grantees*	*IPO objectives; HV Benchmarks; NPM 5; NOM 1-9*	*HV Advisory WG*
3) Child Health	#2 Improving Nutrition & Physical Activity		*FQHC, CSH/WSCC; SDYR; EIS*	*CH&W*	*DCF, DOE, DOT*	*WSCC grantees*	*WSCC objectives; NPM 8; NOM 9,11*	*CSH/WSCC Partners; SPAN*
4) Adolescent/Young Adult Health	#4 Promoting Youth Development, #6 Reducing Teen Pregnancy	*PREP, AEP*	*FQHC, CSH/WSCC; SDYR*	*HIV/AIDs; CH&W*	*DCF, DOE*	*PREP & AEP grantees*	*WSCC objectives; PREP & AEP objectives; NPM 11,12 NOM 10,11,13,15-17*	*CSH/WSCC Partners*
5) CYSHCN	#5 Improving Access to Quality Care for CYSHCN	*CSHCN SIG*	*SCHS CMUs, SPSP grantees*	*EIS,WIC, FQHC, Div of HIV/AIDS,STI,TB;\ Div of PHILEP*	*DCF, DHS, DOE, DOBI, CICRF, NJ Council on DD*	*Local health depts., hospitals, special services school districts, disability specific/ charitable agencies*	*NPM 11,12; NOM 18,19,20,23*	*SPAN/Family WRAP, COCC*
6) Life Course	#7 Improving & Integrating Information Systems #8 Smoking Prevention	*SSDI*		*CH&W*	*DCF, DHS, DOE, NJMS, NJ-AAP, NJOGS, MCHC*		*NPM 13,14*	

Table 1g - Family/Consumer Partnerships

Domain	Priority	*Advisory Committees*	*Strategic and Program Planning*	*Quality Improvement*	*Workforce Development*	*Block Grant Development and Review*	*Materials Development*	*Advocacy*
1) Maternal/ Women's Health	#1 Increasing Healthy Births,	IPO Advisory Committees, Central Intake Advisory Committees	IM CoIIN, NGA	IPO Evaluation	IPO Training & Technical Assistance	Annual public input & public comment		
2) Perinatal/ Infant Health	#2 Reducing Black Infant Mortality,	IPO Advisory Committees, Central Intake Advisory Committees	IM CoIIN, NGA	IPO Evaluation		Annual public input & public comment		
3) Child Health	#3 Improving Nutrition & Physical Activity					Annual public input & public comment		
4) Adolescent/ Young Adult Health	#4 Promoting Youth Development; #6 Reducing Teen Pregnancy	NJAHIVSTDPP CC	PREP State Plan	PREP performance measures; PREP & AEP Surveys	PREP & AEP Quarterly TA	Annual public input & public comment	surveys, brochures	
5) CYSHCN	#5 Improving Access to Quality Care for CYSHCN	FAS Taskforce Cleft Lip/Palate Federation CEC Federation COCC SCHS CM Association	Annual planning in preparation for MCHB Public and/or provider input through family satisfaction surveys	Quarterly and annual programmatic & fiscal monitoring Annual review &/or revision of health service grant Attachment C	AMCHP scholars programs, Quarterly SCHS CM meetings/trainings on statewide systems and programs with parents and providers across FCCS invited, SPAN trainings on local, state, and national topics related to family support,	Annual public and/or provider input; hardcopy &/or public testimony	All surveys, brochures, &/or educational materials developed with family input and tested for cultural competency	Parents educated on self-advocacy through SPAN-Family Voices, NJ AAP, and/or mailings of materials from State, federal, and or disease specific organizations, Title V participation in NJ CDD Partners in Policy Making mock hearings for parents and guardians of

					transition, etc. for CYSHCN, NJ AAP medical home trainings, DOH-Human Resources Development Institute trainings on HIPAA, cultural competency, etc., CityMatch webinars			CYSHCN & self advocates
6) Life Course	#7 Improving & Integrating Information Systems; #8 Smoking Prevention						Website; Stakeholder survey	